DOCUMENT RESUME

ED 148 529 RC 010 259

AUTHOR Bast, David, Ed.; Schmidt, Julie, Ed.
TITLE 2nd Annual Reader: Northern Wisconsin Symposium on Human Services in the Rural Environment (Cable, Wisconsin, October 7-8, 1976).
PUB DATE 77
NOTE 182p.; Papers from the Annual Northern Wisconsin Symposium on Human Services in the Rural Environment (2nd, Cable, Wisconsin, October 7-8, 1976)
AVAILABLE FROM Publications, Center for Social Service, 965 Dorothy Enderis Hall, 2400 E. Hartford Avenue, Milwaukee, Wisconsin 53201 ($3.00); remittance payable to University of Wisconsin -- Extension

EDRS PRICE MF-$0.83 HC-$10.03 Plus Postage.
DESCRIPTORS Alcoholism; Bibliographies; *Delivery Systems; *Health Services; Interagency Coordination; *Models; *Rural Areas; Rural Population; Rural Urban Differences; Rural Youth; Senior Citizens; *Social Services; Social Work; *Telecommunication

ABSTRACT

A collection of papers by educators and health and social services practitioners comprises this reader on human services in rural areas. Part one, "An Overview of Contextual Differences between Urban and Rural Human Service Practice," also includes a paper on how to maintain confidentiality in a rural environment. The "Services to Youth" papers deal with protection of children and the problems of nonconforming adolescents in rural America. Part three looks at "Services to the Rural Elderly," focusing on innovative programming in rural Wisconsin for the increasingly elderly population. "Rural Health Care" considers the overlapping medical-social problems of alcoholism, consumer training in prenatal health care, and the need for more social worker participation in rural primary health care. Use of the telephone to provide consumer health information and of radio technology to improve field communication comprise "New Technology in Rural Human Services." Under "Developing Rural Delivery Systems," an Iowa public welfare agency's modernized delivery system and a new concept for development at a graduate school of social work in Minnesota are described. Part seven is a previously unpublished 22-page "Bibliography of Social Work in Rural Areas." (RS)

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REV 16-01-78

2ND ANNUAL NORTHERN WISCONSIN SYMPOSIUM on Human Services in the Rural Environment READER

Compiled by David Bast
Edited by David Bast and Julie Schmidt

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Published by

The Center for Social Service,

University of Wisconsin--Extension

Madison--1977

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1st Printing 1977

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Address requests to:

Publications
Center for Social Service
965 Dorothy Enderis Hall
2400 E. Hartford Avenue
Milwaukee, WI 53201

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PREFACE

Within the past few years there has been a dramatic reawakening of interest in human services in rural communities. In Wisconsin, the University of Wisconsin--Extension's Center for Social Service has committed itself to a number of rural oriented projects aimed at improving the quality of rural human service delivery systems including the sponsoring of an annual symposium in northern Wisconsin for the purpose of providing a forum for practitioners and educators to discuss and exchange information concerning rural human services. The initial symposium was held in 1975 and featured Joanne Mermelstein and Paul Sundet of the University of Missouri--Columbia School of Social Work as the principal presenters. The 1976 format was expanded to include papers from a variety of health and social services practitioners and educators following a major presentation by Steve Webster and Paul Campbell of the University of Tennessee--Knoxville School of Social Work.

This Reader is a collection of the various papers presented at the Second Annual Northern Wisconsin Symposium on Human Services in the Rural Environment held in Cable, Wisconsin on October 7-8, 1976. Like most Readers, this Reader is an uneven document covering a mix of concerns. It is not intended to be a pretentious scholarly work; it is merely a collection of current thought by rural oriented educators and practitioners which probably would not have been published elsewhere because of the rural focus of the papers. In producing and distributing this Reader, University of Wisconsin--Extension hopes that it is both contributing to the scarce body of rural human service literature available and will be encouraging the creation of more literature concerning rural human service delivery.

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1 AN OVERVIEW OF THE CONTEXTUAL DIFFERENCE BETWEEN URBAN AND RURAL HUMAN SERVICE PRACTICE

The two papers in this section address the question of how rural social work differs from social work practice in the urban setting. In the first paper, two social work educators examine what rural oriented social work educators and practitioners perceive as the major differences between rural and urban social work practice. The second paper prepared by two practitioners, addresses the ever recurring professional dilemma of how to maintain confidentiality in a rural environment where "everyone knows everyone else's business." This typical rural problem--fishbowl practice--is a vivid illustration of basic contextual differences between human service practice in urban and rural settings.

CONTEXTUAL DIFFERENCE IN THE RURAL SOCIAL WORK ENVIRONMENT

Stephen Webster and Paul Campbell

Social work historians point to two conceptual thrusts to explain the early development of the social work discipline: the residual and institutional. Historically, social work practice has reflected the so-called residual approach and later the institutional approach. Both of these rationales for social work intervention are based upon problems that resulted from an increasingly industrialized urbanized America. The residual view saw social work as a source of supplementary rehabilitative services to be utilized when natural social processes broke down. The aftermath of the Great Depression of 1929 nurtured the institutional view which saw welfare services as normal "first-line" functions of a modern industrial society which was itself dependent upon the service complex of larger population centers.[1]

Ferdinand Toennies' polar typologies of gmeinschaft and gesellschaft cultures further supported the urban focus of the field of social work. The gmeinschaft culture, based on the importance of the extended family and mutual support systems, characterized the academic conception of rural life styles. Rural America was seen as being populated by the idealized self-sufficient farmer, able to work the land with the assistance of his family and able to meet most of his needs on the land, requiring little outside contact and certainly no social work intervention.[2] The concept of the gesellschaft society, on the other hand, was based upon the urban industrial complex which fostered disfunctional human systems and led to individuals with overwhelming needs for social work interventions. It was only natural that the training focus of the emerging social welfare profession should be directed towards meeting the needs of the gesellschaft society.

By 1960, two-thirds of the nation's population lived in urban centers, and demographers were predicting continued massive out-migration from rural areas to population centers which were viewed as the cultural focus for Contemporary America. During this period the predominant impression of rural America held by urban sociologists was that of the production of energy, either in the form of food, raw materials, or manpower to support urban industrial centers.

The visibility of urban problems, including the race riots, urban blight and decay, and the threat of increasing industrial automation, directed new federal spending patterns to large metropolitan municipalities.[3] Social problems in the United States became synonymous with problems of urban areas. However, federal fiscal outlays continued to provide limited sources of revenue for rural America; but there was a definitive funding bias towards urban areas. This was compounded by the lack of a definitive federal policy regarding the amelioration or even identification of rural problems.

This lack of federal policy was not challenged by researchers in the rural sociology field. In the past, the professional literature related to rural America has been dominated by the research efforts of land-grant college extension departments and influenced by the U. S. Department of Agriculture. Both of these institutions have followed a "boosterism" style tending to support the image of a predominant farm-based rural economy, even in the face of continued reduction of employment in farming activities.[4]

One is not able to accurately document actual need in rural areas because of the lack of basic information regarding rural people and their problems. This lack of statistical information when coupled with institutionalized stereotyped biases has affected the development of adequate national policies. In the modern data-based society, the absence of the urban-based complex of computer technology has denied the statistical identity of rural populations. The lack of formal mechanisms to document and systematically disseminate data concerning rural people has led to suppression and underrepresentation of the rural problem with the result being far less than a fair chance in the state, regional and national marketplace. This lack of hard data beyond basic census information concerning rural people and their problems is reflective of the lack of federally stimulated research efforts in this area.

However, rural America has social problems. In the areas of poverty, health care, and housing, the incidence of social problems in rural areas is higher than in urban areas. Recent research efforts by a few rural advocacy and lobbying groups have uncovered some shocking statistics about the "other America." For example, rural areas have approximately 31 percent of the population. Yet 44 percent of the poor and 60 percent of the substandard housing is in rural America. One hundred thirty-five counties in rural America have no doctors--an increase in the last decade. Only 12 percent of the nation's

doctors and 18 percent of the nurses work in rural areas. The problems of the rural aged are particularly acute.[5]

Despite the extent of these problems, rural America has not received a proportional share of federal or state program fiscal support. For example, the Comprehensive Employment and Training Act of 1973 allocated manpower funds to "prime sponsors," populations of at least 100,000, placing rural areas and small towns under the category of "balance of the state." Consequently, with 29 percent of the nation's labor force, non-metropolitan areas received only 17 percent of federal outlays for employment and manpower training programs. Only 3.6 percent of CETA on-the-job training funds reached non-metropolitan areas. Federal poverty programs have continually failed to recognize the disproportionate needs of rural areas, with less than a third of food stamp bonuses going to rural people. Only 23 percent of Medicaid payments and 22 percent of Community Services Administration funds find their way to rural people. As a result, rural areas with 31 percent of the nation's population, 44 percent of the poor, and 60 percent of the substandard housing receive only 27 percent of the federal funds for welfare and poverty.[6]

In 1972 Congress, in an effort to address this disproportion, passed the Rural Development Act. This Act was thought to hold great promise of substantial federal involvement in the rural community, but due to the lack of funding and incomplete implementation, there has been no leadership provided under this legislation. Where Congress has authorized federal involvement with major new responsibilities of a similar scope, such as environmental protection, anti-poverty programs or space programs, a new agency has been designed to implement federal policy. However, the responsibility for widescale rural development was given to the Farmer's Home Administration, the largest direct federal lending agency, with little power to implement a goal-oriented program which cuts across all federally administered programs including HEW, HUD and Commerce. Consequently, even the public law designed to focus attention upon rural problems has a parochial approach which perpetuates the bias toward the nation's metropolitan communities.

Despite the recent recognition of the extent of rural social problems, social work has continued its overwhelming urban orientation. Since most recent developments in the field of social work have been based on current research activities, it is perhaps understandable for schools to have developed

urban-based curriculums. There are few graduate schools with identified courses on social work in rural areas, and there are few rural social work majors, despite the fact that better than two-thirds of the graduates of schools of social work take their first job in an area smaller than the town in which they were educated.[7] The entire process is compounded by the fact that schools which educate Ph.D.'s are located in metropolitan areas. It is in these metropolitan areas that graduate students frequently do their research. It would seem that there is almost an institutional bias toward the education of people to work in rural areas. In the two major texts used in social work practice courses in the United States, there are no case examples drawn from rural areas, and, as late as 1971, the section of the *Encyclopedia of Social Work* on rural areas states, "There has been little systematic inquiry into the characteristics of effective social work practice in rural communities."[8] This is not to imply that social work has as a profession totally ignored the rural practice community, for a large number of overworked practitioners have continued to struggle with the problems of rural America, too immersed in problems of existence to challenge the professional educational system's benign neglect. In 1974 a small number of social work educators, sponsored by a Council on Social Work Education grant, were instrumental in developing a task force report for the Southern Regional Education Board. This publication, *Educating Social Workers for Practice in Rural Settings: Perspectives and Programs*, became the leading resource for the focus upon the rural community.[9] Since those early developmental efforts, interest in social work in rural areas has continued to grow so that now there is a core of practitioners and academics sponsoring the concerns of rural social workers and aiming at developing rural social work curriculum materials.

Any emergent minority in the field of social work that declares that working with one type of people or one type of population is different than another must consider itself responsible for identifying for the educational community the areas of difference. This paper's sole purpose is to report the results of the administration of a Delphi to a group of social work educators and practitioners in attendance at a conference on rural social work. They were asked to respond to the question, "What do you think are the major differences between urban and rural social work practice environments?" The following is a compilation of their answers. The differences identified in this process

fall into four broad categories: characteristics of rural clients, differences in the social work task environment, differences in the social, economic, and physical environment, and different social work role conceptualizations.

CLIENT CHARACTERISTICS

- Fewer and less dense populations
- Less formal education (high dropout rates-lower median educational levels)
- Skewed population (very young and very old)
- Different time orientation - slower
- Traditional based life styles
  - Love of place
  - Stress upon masculinity
  - Racism
  - Resistance to outside help
  - Individual pride and independence
  - Sectarian, fundamental religious heritage
  - Family centered
  - Eye-for-eye philosophy
  - Personalism (less group orientation)
- Less political status (in systems other than local community)
- Not as cognitively flexible
- Difficulty in expressing emotions

SOCIAL WORK ROLES

- Workers frequently seen as outsiders
- Lack of understanding of social service networks (resources & services)
- Negative attitudes of urban based and trained workers toward rural populations
- High degree of worker visibility that may affect credibility
- Heightened expectations of work
- Less understanding by community of role of social worker
- Reliance on B.A. level workers from non-human service background
- Worker must be more mobile
- Religious attitudes (as original sin) affect worker effectiveness and relationships
- Necessity for every worker to have strong support and liaison with community power sources
- Increased vertical linkages
- Informal, personalized relationships
- Privacy valued-confidentiality stressed
- Resistance to outside influence
- Less recognition of credentials
- Language barriers (jargon)
- Stress on "who" worker is rather than who they represent as practicing professionals
- Scrutiny of personal life
- Low tolerance of innovation

(SOCIAL WORK ROLES)

- Greater educational difference between worker and client
- Fewer comprehensive programs
- Lack of coverage by Civil Service Policy (increased political and patronage influence)
- Lower salaries, soft money, and decreased job security, less fringe benefits

SOCIAL WORK TASK ENVIRONMENT

- Less specialized services - high demand
- Informal resource network - may be very sophisticated
- Low numbers of professionals
- Lack of private agencies
- Insufficient local funding bases
- Dependence upon soft money
- Lack of client access to services due to poor transportation systems
- Large catchment areas for services delivery
- Deficiency of basic public services (fire protection, garbage, sewer, etc.)
- Lack of "watchdog" agencies and effective evaluation procedures
- Political influence on service delivery system at all levels
- Vertical linkages inhibit local control
- Conservative attitudes and political processes
- Overlap of regional county, local service delivery systems - domain protection results
- High level of visibility and scrutiny by informal means or word of mouth
- Small agencies and fewer innovative approaches
- Less formalized standard operating procedures
- High influence of media (monopoly of local forum)
- Less trained practitioners
- State and federal mandates which conflict with local desires

SOCIAL AND PHYSICAL ENVIRONMENT

- Less dense population - poor transportation system
- Less social mobility - people physically separated
- Religion is primary shaping agent
- Monolithic economies - lack of diversity of economic base
- Less disposable income
- Significant recent in-migration after years of out-migration
- Conservative political power structure
- Federal mandates frequently remove local control of program implementation
- Significant geographical barriers
- Local pride contributes provincialism
- Lower crime rates - fewer law enforcement personnel
- High unemployment and under-employment levels
- Greater problems - fewer resources

(SOCIAL AND PHYSICAL ENVIRONMENT)

- Reliance upon informal systems
- Less formalized recreational and leisure-time activities
- Lack of understanding by urban based resource systems of rural problems
- Distance, geography, and climate are factors
- Less industrialization
- Fewer competing power sources
- Overlapping roles of public officials
- Lack of formalized data base

These data should be seen as inputs into a much broader and more positive investigation of rural life. There is an inherent danger in a formal comparative study of cultural difference because the "difference" or "deficiency" model is based on a mainstream characterization which measures American culture. This results in perpetuation of an outdated stereotype that implies that the focus for change strategies should be to close the "difference" gap by uplifting those in the subculture.

These identified differences necessitate an examination, we feel, of current practice models. We urge further statistical research and analysis of these differences in order to incorporate more rural and small-town content in social work higher education. These efforts should imply changes in present educational programs and continuing education and staff development efforts to retrain human service professionals who practice in the rural context.

FOOTNOTES

[1]Harold L. Wilensky and Charles N. Lebeaux, *Industrial Society and Social Welfare*, (New York: The Free Press, 1958), page 138.

[2]Alfred J. Kahn, *Theory and Practice of Social Planning*, (New York: The Russell Sage Foundation, 1973), page 29.

[3]Charles F.Grosser, *New Directions in Community Organization*, (New York: Praeger Publishers, 1973), page 6.

[4]Stephen A. Webster and Paul M. Campbell, "1970's and the Changing Dimensions in Rural Life - Is a New Practice Model Needed?" Presented at the 1976 Council on Social Work Education Annual Program Meeting, Philadelphia, Pennsylvania, March 1976, page 12.

[5]*Toward a Platform for Rural America*, Rural America Inc. and Rural Housing Alliance, Washington, D.C., 1975, page 13.

[6]Stephen Webster and Paul Campbell, op cit, page 19.

[7]Burt Caswell, speech during the Field Instructor in Rural Settings Workshop at the Council on Social Work Education Annual Program Meeting, Philadelphia, Pennsylvania, March 1974.

[8]Leon Ginsberg, "Rural Social Work," *Encyclopedia of Social Work* Vol. II, 1971, pages 1138-1144.

[9]*Educating Social Workers for Practice in Rural Settings: Perspectives and Programs*, Southern Regional Education Board, Atlanta, Georgia, July 1974.

[10]Charles Valentine, *Culture and Poverty: Critique and Counter-Proposals*, (University of Chicago Press, Midway Paperback Text Series, 1969).

CONFIDENTIALITY: WHAT IS PRIVATE IN A RURAL AREA?

Joanna Sherman and Lucy Rowley

The issue of confidentiality in the delivery of human services is complex. Professional ethics, recording systems, legal ramifications, even the physical plant are areas to be considered. In the rural area, limited resources, overlapping of worker-client roles, increased visibility and extended kinship and friendship ties are also dimensions of the issue. What is public and what remains private is differentiated by a very fine line. When it comes to the definition of this "fine line" of the practice of confidentiality, we are pushed to conceptualize beyond the operational constructs with which we were prepared in our professional training. It is not clear enough to us to say that the profession (in our case, social work) defines relevance regarding this issue as practice in keeping with professional standards, or that the community definition is the accomplishment of its goals.

The intricate social matrix of rural life has behaviors, whether meant to be public or not, fed into it, easily, readily, and steadily. Extended family and friendship relational ties are the basic dynamic of this matrix. Worker-client roles are not separate from the fabric of this life but are the functional transmission links of change within it. Hence in the rural area lifestyle, almost all information is personal and personalized. Much is public, accessible either from public records or from personalized inference based on observation, rumor, or gossip. What remains private, therefore, seems entirely debatable and in need of protective service in its own right: hence our concern with the issue of confidentiality.

Limited Resources, or: "What We Don't Have Does Hurt Us."

Waushara County, Wisconsin, has a population of approximately 16,000 persons. The largest town, Wautoma, the county seat, accounts for 10 percent of that population. The rest is scattered in smaller communities (300-500 population) and in more isolated rural dwellings. Waushara County is typical of many rural counties in Wisconsin. Per capita income in 1975 came to $3959.00. Twenty-three percent of the population, by family groups of four, had an

income of $3,000.00 or less according to the 1970 Public Health Department statistics. Unemployment averages 9.2 percent almost any time of the year. The highest month this past year (1976) was March - 16.5 percent. The lowest month (August) provided a 6.9 percent figure.

Resources necessary to deal with the types of problems presented to service delivery organizations are limited in areas such as described above. Doctors are a long way off; lawyers if available are expensive; clinics to provide mental health services may have staff available only once or twice per week; schools are an hour's ride on the bus; nurses are heard about; sheriffs don't come out very often; and social services is where everyone else goes to get their food stamps. Decent housing must be in another county; and jobs, if available, are often so far away that transportation and child care expenses outweigh possible earnings. We are all aware of these facts. We are, hopefully, also aware that the Departments of Social Services and the 51.42 Unified Services Boards (providers of mental health, chemical dependency, and developmental disability services) must carry the weight of providing and/or promoting services in the rural areas.

"There are repeated and accurate reminders that smaller communities have fewer professional resources than the large city - not only professional individuals but fewer formally organized services. In many areas the only social service organization, for example, is the county welfare department. But this may be more a benefit to the smaller community than a problem... In areas where people know each other, organized change efforts become both visible and salient... Visibility provides opportunity for new change to gather momentum... Visibility enormously enhances evaluation. By assuming a community perspective rather than a target population perspective, the planner can identify the nature of the consequences that fall upon those individuals and organizations who inevitably pay the price for change when resources are limited."[1]

The nature and organization of the typical resources in a rural Wisconsin county are demonstrated in Diagram A on the following page.

Overlap of Worker-Client Roles, or: "...It Goes With The Territory."

Clients of human service agencies in the rural areas approach their human service worker counterparts with many of the following beliefs: 1) Friendship

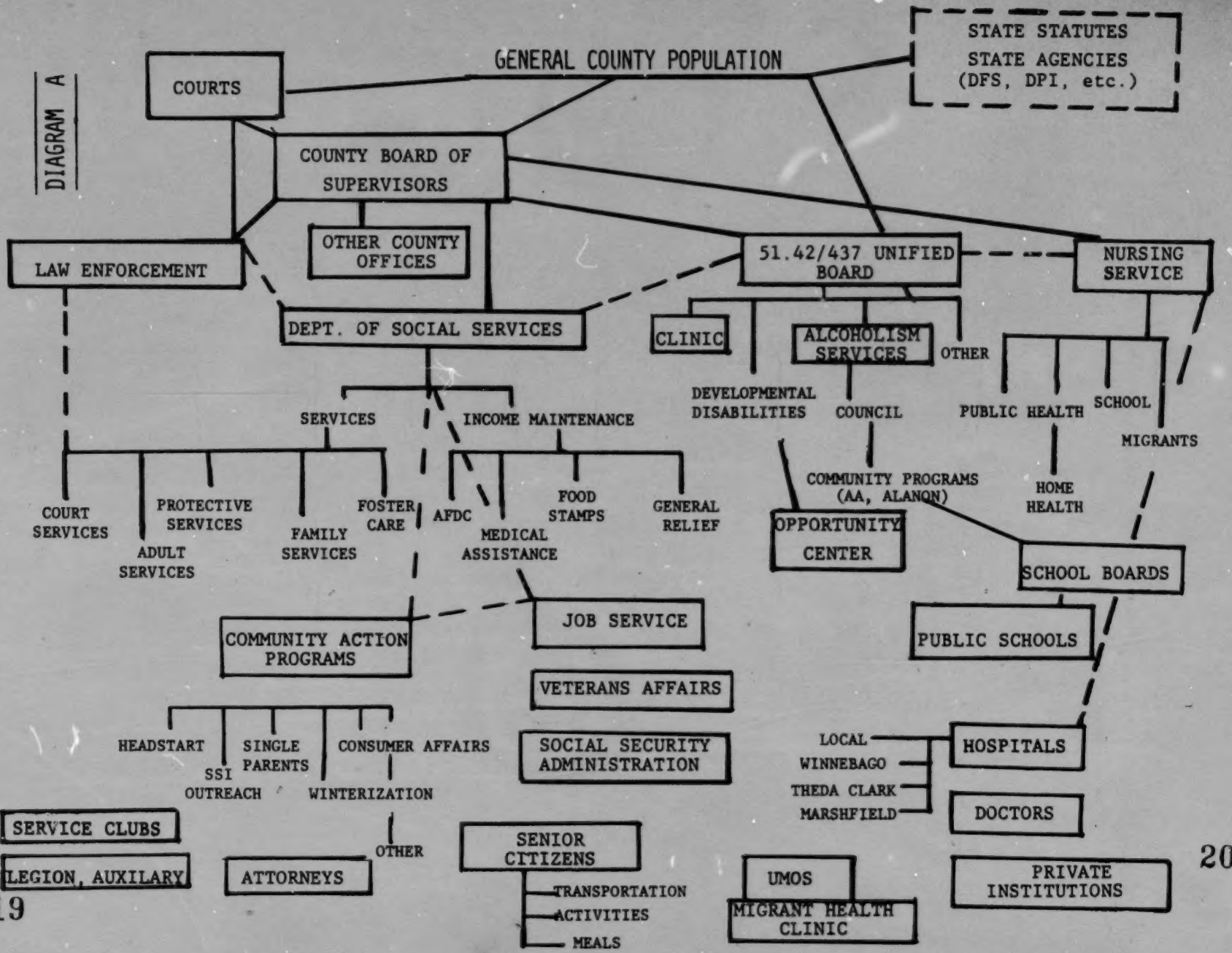
DIAGRAM A
GENERAL COUNTY POPULATION
STATE STATUTES
STATE AGENCIES
(DFS, DPI, etc.)
COURTS
COUNTY BOARD OF SUPERVISORS
OTHER COUNTY OFFICES
LAW ENFORCEMENT
51.42/437 UNIFIED BOARD
NURSING SERVICE
DEPT. OF SOCIAL SERVICES
CLINIC
ALCOHOLISM SERVICES
OTHER
DEVELOPMENTAL DISABILITIES
COUNCIL
PUBLIC HEALTH
SCHOOL
MIGRANTS
SERVICES
INCOME MAINTENANCE
COURT SERVICES
PROTECTIVE SERVICES
ADULT SERVICES
FAMILY SERVICES
FOSTER CARE
AFDC
MEDICAL ASSISTANCE
FOOD STAMPS
GENERAL RELIEF
COMMUNITY PROGRAMS (AA, ALANON)
HOME HEALTH
OPPORTUNITY CENTER
SCHOOL BOARDS
COMMUNITY ACTION PROGRAMS
JOB SERVICE
PUBLIC SCHOOLS
VETERANS AFFAIRS
HEADSTART
SSI OUTREACH
SINGLE PARENTS
CONSUMER AFFAIRS
WINTERIZATION
SOCIAL SECURITY ADMINISTRATION
LOCAL
WINNEBAGO
THEDA CLARK
MARSHFIELD
HOSPITALS
DOCTORS
SERVICE CLUBS
LEGION, AUXILARY
ATTORNEYS
OTHER
SENIOR CITIZENS
TRANSPORTATION
ACTIVITIES
MEALS
UMOS
MIGRANT HEALTH CLINIC
PRIVATE INSTITUTIONS

is a functional human relationship; it is the most familiar, most frequently experienced form of ongoing human relationship in the rural area. 2) In rural neighbors there is an active and ever-present curiosity about what happens to his friends and neighbors. This interest, curiosity and inquisitiveness extends as far geographically as his friendships. 3) Professional people (people with titles) are containers of expert knowledge. They are different from "us" because they know more than we do, because they know better things, and because they are a different "sort" or from another place.

Workers in the rural human services approach their clients with an initial corresponding list of assumptions: 1) I am alien in a strange county (this close-knit society). My education, social class, and professional allegiances set me apart. 2) Everyone is watching what I do; I must be as obvious as a sore thumb. 3) I surely disagree if not outright conflict with the prevailing norms and values of this place and these people.

These are certainly different perspectives from which to meet each other. If these assumptions did bear out in our experiences with one another, the most we could expect to develop over time would be complimentary role relationships or life-styles in our efforts to deliver human services. We suggest, however, that worker-client roles do not, in fact, arise from such disparate preconceptions. Neither are roles preordained by the formal structures. When roles converge, as they must in the rural area, they overlap.

The worker's approach to his rural environment embodies a perception of his own alienation and the differences from those with whom he is destined to work. This is of particular interest because in recent literature dealing with the nature of delivering human services in rural areas, it is pointed out that it seems not so important the particular skills or specific techniques a worker brings to the task, but how he fits into the life-style of the area as to whether he succeeds or fails in accomplishing the task.[2] Rural social workers, whether in the employ of social services or a community mental health center, are different from other social workers in several specific ways: 1) The kind of educational background they come from. 2) They way in which they first encounter the human service professions, and 3) The motivational sources impelling him to the particular place of employment.[3]

The rural social worker in mental health is also different from the other

professional disciplines within his own agency setting. That is, he is distinguishable on specific role dimensions from physicians, psychologists, and nurses practicing from the same agency base. The social worker as defined here comes to his rural area job measurably motivated to achieve affiliation with others. Since this is a personal, life-satisfying desire on his part and since professional support systems are notoriously absent in rural practice, is it not logical that the social worker at least is seeking neighbors, friends, and the rather total fabric of overlapping roles?

The nature of the fabric of rural life is such that both the client and the worker are, foremost, fellow residents. The fire on your neighbor's land is as important to you as if lightening had struck your barn. In a summer of drought like this one we would all have gone up in smoke if we did not merge to fight it. The behavioral realities of rural living, including the planning, provision and delivery of human services, are responses to environmental exigencies. Real responses of real people, dealing with their problems are determined by the very nature of their rural life.

There is also a mutuality of the experience of being fellow citizens that overrides preconceptions about professional roles. You may align with various members of the community to fight against politicians or businessmen. The section of the county you live in may be in need of more snowplowing service or better road surfacing, or transport for self or produce to town. As citizens you support, elect or defeat condidates and issues. You get better roads or stay stuck. In any case you must define and resolve problems together.

With the exposure that this kind of behavior calls for, there is not only personal risk, but also the need for continuous, mutual, assessment and evaluation. The greater the degree of integration in the nature of rural life, the greater the degree of overlap in worker-client roles. When you live this interdependently, what is public and what is private? Your feelings are private but behaviors are public. All, however, are personal.

Increased Visibility: or, "What You See Is What You Get?"

While coming out of the office one day after closing hours to a nearly empty parking lot, two small boys were observed riding by on bicycles. "What time is it?" called one to the other. Glancing around he replied, "I don't

know but it must be after 5:00, social services has gone home." Increased visibility: Fact in the rural area. "Is something wrong with Mrs. Smith?" inquired a neighbor in a call to the adult services worker. "I saw your car there all morning?"

Having lunch in a local restaurant with one of the county nurses produced another incident. The waitress who appeared to take the order was a client against whom the agency had taken legal action regarding her children... The opposing softball team in the city league, perhaps to be known as the "AFDCU' ers?" Increased visibility: the client as well as the services worker.

These observations or what is seen and assumed, over and above what may be heard, are realistically added on to the amount and kind of information presented to the worker by the client himself. This is an area where control over personal information is lacking, whether or not there are the legal safeguards to protect the client from the general knowledge that he is in receipt of some type of service - financial, family, or personal.

During lunch hour the other day one of our income maintenance case aides was standing in line at the local meat market - counting pennies, hot dogs, and the specials of the day. In the next line over she noticed a man who had just come from the agency that morning, having been issued an allotment of zero purchase food stamps. He was using the stamps to purchase top sirloin and rolled rump roast. Visibility...

Extended Friendship and Kinship Ties: or, "I'm My Own Grandma!"

How different and difficult it can be (at first glance) to learn that the fairly young but nearing middle-age woman who is becoming your client is depressed, hysterical, hypochondriacal, and anxious. She is also: 1) the wife by a second marriage of an illiterate laborer; 2) the step-daughter of her own sister (her stepfather divorced her mother and married her sister), 3) the mother of three children under 10 years of age - two by a former husband whose parents live up the road a piece (across the county line), one of the two was actually born out-of-wedlock, the third child is from the present marriage; 4) residing a mile from her mother's place; 5) using both sets of grandmothers plus assorted cousins, aunts and second cousins as baby-tenders on frequent occasions - who says she feels like running away, in fact, she

keeps her full bottle of valium on hand just in case...

If, as Vidick and Bensman suggest, systems of illusions are the dominant feature of small town (read "rural") life, and such systems are comprised of social characteristics such that they control the human interactions by defining and defending the community mores (read "norms, values, lifestyles"), then reality assessment cannot be accomplished in situations such as described above except at the level of intimacy in the professional relationship, or the social interaction.[4] What is as intimate as "gossip?" We suggest that the worker-client interaction - the professional relationship - is or is likely to be.

Second, third, even fourth generation family problems may be encountered by the rural services worker. Repetition of the characteristic problem patterns are reinforced by the family subculture as well as the general community's response. The child born out-of-wedlock that was not wanted by the mother but was kept because it was the family's way serves as a constant reminder to that mother of the situation she was in. The child is also a built-in control of the mother's behavior, particularly if she should want to leave the family system. Resolution of a problem in this type of situation would of necessity call for the disruption of the intimacy of the home - removing to the outside either the child or the mother. Such external treatment may have a "shattering" effect on the family's operant systems of illusions. In such a situation they may in fact accept the reality, but will most certainly resent the agent, the services worker.

It is difficult, if not impossible, for a rural services worker and his client to make changes that are not attended to by family and friends. It seems fruitful, therefore for us to continue to explore and redefine confidentiality in this type of situation. When everyone (or nearly) knows everything (almost) there is to know about what is happening, what is in fact confidential?

Client's Right of Privacy

Just recently we received in our offices a flyer from the Division of Family Services entitled, "Protection of Individual Privacy and the Provision of Social Services." Timely. Among the privacy rights listed, two deserve comment here: #1 reads, "Information you give about yourself cannot be given

to anyone without your consent." And #4 reads, "You have a right to know that information is being kept about you (including computer records) and to correct any information that is not right."[5]

In an article entitled, "The Assault on Privacy," Arthur Miller has some pertinent comments: "It should be evident to all that we live in an increasingly information based society... Ever since the federal government entered into the taxation and social welfare spheres, greater quantities of information have been sought from citizens and recorded; moreover, in recent years access to governmental or institutional largesse - particularly in the human service field - has increasingly depended upon the individual's willingness to divulge private information.[6] This implies some risks which need to be minimized if possible by the services worker. Miller also suggests some steps along this line: 1) That those who handle individualized data (from student records to welfare lists) have an obligation to guard the privacy and confidentiality of the human beings whose lives are reflected in the dosiers. 2) Certain types of information should not be recorded. 3) Access to data should be limited. 4) The data handler must become more honest and open with the data subject (individual having access and opportunity to challenge). 5) Information must not be allowed to petrify.[7]

In a workshop entitled "Confidentiality - the Legal Ramifications" on August 27, 1976, in Green Bay, Wisconsin, Mrs. Sandra Nye (J.D.M.S.W.) from the Institute for Juvenile Research in Chicago, stressed the *duty* of confidentiality - keeping mouths and records secure. Other than the obvious ethical considerations, it was well pointed out that breach of this "duty" was actionable. After-all, the person who has the right to consent to receive service has the right to consent to the disclosure of the information regarding that service. Client consent - informed, written and specific - appears to be the best and most secure policy.

The "Gatekeeper" Function

Of necessity in providing services in the rural area, outside resources have to be utilized. In the process of making such referrals, a services worker role has become apparent which is unique to the worker - not overlapping with the client. This is what we have chosen to call the "gatekeeper" role. Some information that is important to the worker in his efforts may in fact be

of little benefit in the client's use of an outside resource. The release of information in these instances must be highly selective. It is the worker, acting in the gatekeeper role, who determines what information shall be accessible to the outside resource. This role is also non-identifiable to the local community as it is only activated upon referral to an outside resource. For example: A client, mother of a developmentally disabled child, being seen by the clinic to establish that child in an institutional program, sought consultation regarding herself - relating to an occupational injury and a subsequently thwarted workman's compensation claim. In dealing with a variety of state bureaus regarding this situation, a specific written release of information was provided to each of the several agencies contacted by the worker on the client's behalf. These releases expressed the intent to those agencies to use the worker as both a source and recipient of confidential information as well as to acknowledge the familiarity of the state bureaucracies with information rather than people and with the ongoing use and necessity of legal services. In following this case through, a subsequent referral was made to an industrial injury clinic to document the extent of disability suffered and the inability to continue in the type of work role previously held. In this referral to the clinic, only the client's personal medical history and the information that Workman's Compensation was paying for the evaluation was shared with the clinic's intake personnel. The worker subsequently accompanied the client during admission to the clinic.

Conclusion

We can exert some control over the information a client gives us; either by not asking or by telling him not to give it. We can also control the legitimacy of the information we have (e.g. hearsay, gossip or presumptions) by sharing records we have with the client and asking for verification. We cannot, however, bind our client to our ethics regarding sharing information about our contacts with him. We can really only assume that the client does share it with others. This may in fact be neither here nor there, except that to presume the client follows our assumptions regarding confidentiality is false. What emerges as relevant to us then in the redefinition of confidentiality suggests something like this: Not to worry about information or even non-information that is publicly known or assumed, whether about oneself or one's client, rather to act with the client upon current verifiable, entrusted

information in the private context of the helping relationship and in his behalf as gatekeeper with all other resources.

FOOTNOTES

[1]Mary Wylie, "Nonmetropolitan Social Planning," *Social Work in Rural Communities*, ed. Leon Ginsberg, C.S.W.E., New York, 1976.

[2]Robin and Wegenfeld, "The Rural Community Mental Health Center," *Social Work in Rural Communities*, ed. Leon Ginsberg, C.S.W.E., New York, 1976, pages 79-81.

[3]Ibid, page 76.

[4]Edward Buxton, "Delivering Social Services in Rural America," *Social Work in Rural Communities*, op cit, page 34.

[5]DFS Bulletin, "Protection of Individual Privacy and the Provision of Social Services," June 1976.

[6]Arthur R. Miller, "The Assault on Privacy," *Psychiatric Opinion* Vol. 12 #1, January 1975, pages 6-14; 7-8.

[7]Ibid, page 10.

2 SERVICES TO YOUTH

There is a common tendency to perpetuate the agrarian ideology that rural life is somehow innately better for youth than urban life. Unfortunately, the reality is that small town youths have just about as many confrontations with the juvenile justice system as do their urban counterparts when comparison is made on a per population basis.[1]

The first paper in this series of three deals with the protection of children. Emphasis is placed upon how the rural context effects the development of a delivery system. The following two papers focus upon the problems of the nonconforming adolescent in rural America and suggest the usage of social programming as an alternative to the more traditional referral directly into the juvenile justice system.

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[1]National Institute of Mental Health. "Teenage Delinquency in Small Town America," Research Report-5, Stock No. 1724-00401, Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, 1974.

CHILD PROTECTION IN A RURAL SETTING

Georgianna Shepard

Child protection in a rural setting constitutes a unique challenge. The beauty of the environment often masks the socio-economic deprivation which may be present in the rural as well as the urban areas of the United States. Such deprivation contributes to parental stress and family crisis, which may, in turn, precipitate child abuse. The treatment and prevention of child abuse in the rural environment is particularly difficult, due to the absence of essential resources.

Representative of those rural areas with a high level of socio-economic deprivation is Douglas County, located in the northwestern corner of Wisconsin. The County presents higher than state-wide averages of divorce, unemployment, alcoholism, and public assistance recipient load. According to the five year averages from 1968-72, Douglas County is tied for third place with urban Milwaukee County in the rate of divorce.[1] In regard to unemployment, Douglas County runs consistently above state and national levels. For example, in March, 1976, the unemployment rate was 11.4 percent in Douglas County, compared with 7.0 percent for Wisconsin and 8.1 percent for the nation.[2] Even these harsh statistics do not fully portray the employment situation in rural Douglas County, where a large segment of the work force depends on seasonal woods work or marginal farming. Alcoholism is another striking problem. According to data compiled by the Douglas County Comprehensive Planning Board, the county's per capita incidence of alcoholism is among the highest in the nation.[3] The Wisconsin State Alcoholism Plan indicates that over 15 percent of the adult population are identified as alcoholics or alcohol abusers.[4] Finally, public assistance recipient load provides just one indication that the County is an area of economic deprivation. In Wisconsin, the County ranks consistently around twelfth or thirteenth in public assistance recipient load, although there are approximately 21 Wisconsin counties larger in population.[5]

Other factors, such as lack of adequate housing and insufficient opportunity for minority groups, could also be cited, but the major point has been made. Socio-economic deprivation is present in rural as well as urban communities. While definitive studies are yet to be made, it is obvious that the

presence of economic deprivation can do nothing to add to family stability and is likely to contribute to parental stress.

Unlike many urban areas facing similar problems, rural areas are typically lacking in resources necessary to combat them. Some of the scarce or absent resources are public transportation, adequate recreational programs, basic health and social services, day care, adequate housing, vocational education, highways, museums, libraries and entertainment. Even though state and federal monies may be available to develop some of these resources, the typical county board may not apply for aid, being unwilling to supplement these monies with county funds. As indicated by Edward Buxton in his article, "Delivering Social Services in Rural Areas," "...county boards do not see themselves as examining human needs and developing resources to meet these needs, but rather conceive of their role as one of holding back the director so that funds will not be over-expanded."[6]

Unfortunately, the matrix of rural socio-economic deprivation combined with short resources does not tell the full story of factors which contribute to parental stress. In addition, the few existing resources are concentrated in areas of relatively dense population, to the neglect of persons in rural areas. Douglas County, Wisconsin, exemplifies this concentration of resources. The population of over 44,000 persons is located in two principal sectors, the City of Superior and "the county," as the area outside of Superior is called. The population of Superior is over 32,000 and the remaining 12,000 persons are dispersed over the rural countryside. Formal resources such as museums, recreation, vocational education, public transportation, and libraries tend to be centered in Superior. *All* formal health and social services, without exception, are located in Superior. Persons living on the perimeters of the county must drive distances up to forty miles for service. The striking concentration of resources in areas of relatively greater population points to the isolation of the rural family from formal services. The lack of any adequate public transportation makes the isolation especially dramatic. I have observed the same pattern as I have resided in rural counties across the nation, including Berkshire County, Massachusetts and Antelope County, Nebraska. Having viewed the rural setting from this perspective of scarce, inaccessible formal resources, it is possible to examine the effect on child abuse.

The thesis of this article is that the rural setting may contribute to child abuse in several ways:

1. The presence of socio-economic deprivation contributes to parental stress and family crisis. Child abuse may be the result.
2. Parental stress and family crisis are difficult to prevent and treat in the rural environment since scarce, formal resources concentrated in areas of relatively dense population tend to isolate the rural family from essential services.

A review of the literature on child abuse gives substantial support to the fact that socio-economic deprivation contributes to parental stress. Brandt F. Steele, M.D., comments:

> (There is) "increasing knowledge that child abuse and neglect occur among families from all socio-economic levels, religious groups, races and nationalities. These facts should not be interpreted to deny the profound effect which social and economic deprivation, housing problems, unemployment, and subcultural and racial pressures have on the lives and behavior of the caretakers who abuse and neglect their children. Any stress can make life more difficult, and the ramifications of poverty can make anything worse than it would otherwise be."[7]

Even more specifically, socio-economic deprivation contributes to family crisis which is a *precipitating* although not a causative factor in child abuse. Doctors Kempe and Helfer summarize three major pre-conditions which must exist before a child is physically injured by his parents or guardian. First, the parent or guardian must have the potential to abuse. Second, there must be a child who is seen as different by his parent or guardian. The third condition is summarized in this way:

> "Finally, there must be some form of crisis, or a series of crises, that sets the abusive act into motion. These can be minor or major crises - a washing machine breaking down, a lost job, a husband being drafted, no heat, no food, a mother-in-law's visit and the like. It would seem unlikely for the crisis to be *the* cause for the abuse, as some would like to believe; rather it is the precipitating factor."[8]

Looking at the examples of Doctors Kempe and Helfer, it is obvious that crises are exacerbated by socio-economic deprivation. Certainly it would not be accurate to say that all crises are so caused or that all crises lead to child abuse, but one thing is certain; the problems of poverty and social alienation contribute to parental stress and family crisis.

So far the discussion of the role of socio-economic deprivation in child abuse has not set off the rural setting from the urban. The striking fact is merely that these problems are so prominent in the rural environment. It is when we look more deeply at the prevention and treatment of child abuse that we see the unique aspects of the rural environment. As we noted earlier, the few available resources are inadequate and are concentrated in areas of relatively dense population. The troubled rural family is often effectively isolated from every form of help which might make their plight bearable. For example, a poverty striken couple with marital problems aggravated by alcoholism have no easy access to divorce counseling or treatment for chemical dependency. The couple has little relief from the care of children since there is usually no formal day care program in the country and certainly no crisis-centered child care center. Even the informal resources of relatives and friends may be located in the nearest town with no access by public transportation. Under these circumstances, parental stress rapidly mushrooms into a crisis when the mother becomes ill or the father loses his job. The crisis can become a precipitating factor in child abuse.

Thus the opportunity to prevent a family crisis is often lost. In addition, if child abuse does occur, treatment is often hindered by the rural setting. The abuse may not come immediately or even eventually to the attention of the authorities, due to the isolation of the family. If the child is brought to the distant hospital, the changes of this facilty having a community -based child abuse treatment program, such as that described by Kempe and Helfer, are remote indeed.[9] Other remedial measures such as social casework, psychotherapy, vocational rehabilitation, chemical dependency programs and financial aid are ordinarily located in the county seat and are not readily available to the family.

Given these conditions, how are we to respond to the unique challenges of child abuse in the rural setting? Certainly there are no tried and tested answers. My suggestions center around the scarcity and availability of resources. First, given the scarcity of resources, each agency needs to plan its priorities with *careful study of need.* Once the existence of child neglect and abuse is documented, there is some hope that the community will make child protection a priority. Second, scarce resources make it essential that *agencies use all their resources and use them with imagination.* For example, are para-

professionals such as homemakers and outreach workers fully utilized in diagnosing and treating child abuse and neglect? Are volunteers working with neglectful and abusive parents? Is income maintenance fully utilized as a means of decreasing parental stress and preventing crisis? Third, scarce resources make *coordination especially important* in a rural community. Do law enforcement and social service work closely together in a trustful relationship on child abuse and neglect cases? Is the juvenile court seen as an important tool in helping families under stress? If there is a mental health center, is it engaged in outreach to prevent parental stress and family crisis? Is there close case coordination effected through a multi-disciplinary child protective team or less formal case conferences?

Availability of resources to the rural resident lead to a host of additional suggestions regarding *outreach*. Rural residents must be fully informed of the formal channels for child abuse reporting and be encouraged to use these channels. Use of the mass media is indicated as well as utilization of the informal networks which include town chairmen, ministers, and social service clubs. Making the necessary remedial resources available to the rural resident may necessitate door-to-door canvassing, a county-wide crisis telephone line staffed by volunteers, and outstationing services. Outreach may be extended by the development of a county-wide committee on child protection.

Community organization is another essential ingredient in developing child protective services. As Dr. John Musick has forcefully pointed out, the community must be helped to have an impact on social policy.[10] In order for this to occur, the constituency of public agencies must be made accountable for the needs of rural residents, rather than only for the control of funds. Citizen groups and informal advisory committees can play an important role in informing county boards regarding the needs of rural families and the human cost of not meeting needs with adequate and available resources.

Dealing with child abuse effectively in a rural setting demands that we recognize the necessity for such aggressive menas of combating the isolation of the rural resident from services which prevent and treat parental stress. Failure to offer services to relieve family crisis may lead to child abuse. Lets not be lulled by our pastoral surroundings - rural America requires innovative and aggressive efforts in child protection.

FOOTNOTES

[1]"Marriage and Divorce, Wisconsin, 1966-1970," Department of Health and Social Services, Division of Health, Bureau of Statistics, Section of Statistical Services. Table 22.

[2]Wisconsin State Employment Office, Superior, Wisconsin. Telephone conversation, April 1976.

[3]David Hon, Douglas County Comprehensive Planning Board, interview on June 14, 1976.

[4]Wisconsin State Alcoholism Plan for the Prevention, Treatment and Control of Alcohol Abuse and Alcoholism for the Fiscal Year 1975-76.

[5]John Barrett, Director, Douglas County Department of Social Services, memo, March 1976. His information was based on monthly statistics issued by the Division of Family Services on Public Assistance in Wisconsin.

[6]Edward Buxton, "Delivering Social Services in Rural Areas," *Public Welfare* Vol 31, No. 1 (Winter 1973).

[7]Brandt F. Steele, M.D., "Working with Abusive Parents from a Psychiatric Point of View," U.S. Department of Health, Education and Welfare, Publication No. (OHD) 75-70, page 3.

[8]C. Henry Kempe, M.D. and Ray E. Helfer, M.D, *Helping the Battered Child and His Family*, pages XIV-XV.

[9]Ibid, page XV.

[10]Dr. John Musick, remarks at a workshop, "Social Work in the Twin Ports," University of Wisconsin--Superior, April 9, 1976.

THE DELINQUENT YOUTH IN THE RURAL AREA

Stephen Dahl

The Waushara (Wisconsin) County Department of Social Services provides services to those youth who come within the jurisdiction of the County's Juvenile Court system. The majority of these cases are delinquency, in need of supervision, or dependency matters. The referrals are usually ordered by the Juvenile Court, or are informally referred by the Waushara County Sheriff's Department. The Agency provides services to youth with problems labeled as truancy, runaways, criminal behavior, and drug and alcohol abuse. There are approximately 65 youths per year who are receiving services either from an agency social worker or the county's Juvenile Court worker. This is approximately one-fifth of the total number of children who come in contact with the Sheriff's Department. In 1975 there was an approximate total of 300 children who came to the attention of the county Sheriff's Department and Juvenile Court. This is nearly 7.0 percent of the County's total juvenile population.

The rural youth who enters Waushara County's juvenile court process typically is male and has experienced other problematic behavior within his social environment. His family will likely describe their child as being difficult to control, and spending an exaggerated amount of time with his peers. The child will likely have a school history of poor grades and attendance. He plans to drop out of school at age sixteen, if he hasn't already done so. The juvenile will usually have a difficult time in being able to objectively discuss the reasons,or "why" he participated in an unlawful incident, or refused to attend school. The youth can, however, tell you a lot about himself by his indifference, distrust, and verbal complaint about his parents, teachers, or other significant people within the child's surroundings.

The child can be described as being alienated from many adults and peers. The degree of the child's alienation will largely depend upon how supportive the child's social systems have been in the past. If a child has had a positive relationship with the significant people in his environment, he will likely continue to exhibit appropriate behavior, and maintain a more positive attitude about himself. The delinquent child generally has had a lesser number

of positive experiences within his environment. The family and school systems, typically, will grow more frustrated and intolerant towards a child's inappropriate behavior. This has a tendency to strengthen a child's resentment and alienation.

The delinquent youth who seemingly grows more alientated will also seem to be experiencing and "identity crisis." This is normal for most adolescents who are growing more independent from the adults in their life. The adolescent who has grown distrustful and feels rejected from his adult world will, however, have difficulty in completing this developmental task. He will likely compensate by seeking emotional support, acceptance, and status from his peers. These peers are usually other adolescents who are experiencing similar problems at home and school. The child will largely over-identify with them. His relationships with his peers become more important than the expectations of his family and school. The adolescent, for example, will want to continually be with his peers, and he won't care if he gets home at a reasonable hour in the evening. He may also skip classes more frequently at school with his peers. It is likely that the youth will again seek refuge or support from his peers when his parents and school officials try and regain control of the situation. The youth who is engulfed within this group process will probably maintain a feeling that it is "us against everyone else". This not only includes many adults in the youth's life, but other peers who are conforming to traditional expectations from their family and school. This youth, for example, will identify himself as being separate from the "jocks" at school. They will adapt their own style of dress and probably participate in their own unique activities. This type of cohesiveness has a tendency to increase the likelihood that the youth will engage in more deviant behavior within his group. A delinquent act, for example, will give the youth an opportunity to gain more recognition or status within their group. This type of process is strongly operative within Waushara County, since most youths are accompanied by a companion in their offense. The majority of our referrals are typically group type offenses, such as the possession of alcohol or marijuana, vandalism, theft or burglary, and truancy.

This understanding of delinquent behavior is not just unique to the rural areas. There are, however, three factors which we believe are contributing to the occurrence of delinquent behavior in our area, and

aggravating the youth's alienation and identity crisis. The first factor is that a youth in a rural town is much more visible to other people, comparably to an urban area. This greater visibility has a tendency to reinforce or strengthen people's perceptions towards a particular child or anyone else. The reason being that people have more opportunities to think about another person, merely because they come in contact directly or indirectly with each other more often. They will in other words, (1) be in closer proximity to one another and therefore see each other more often, and (2) have a greater access to information about each other through the informal communication network of a rural town. A major aspect of this process is that it often leads to many distorted perceptions of other people, since most people are only exposed to limited information. The child who develops problems within school or with the law, or has had a family with a history of problems will likely find himself labeled as a troublemaker, a freak, undeserving, or different. Many townspeople, for example, will know if a child was contacted by a police official or skipped out of school the other day. The child is certainly very visible when he is standing around on main street with his friends who have long hair and dirty clothes. These types of things are likely to reinforce people's negative perceptions towards a particular youth. A youth can very easily become conscious of these attitudes by the indifference or hostility which others might project. The youth, for example, could be unjustly harassed by the town policeman, or be unfairly denied a job, or told not to return to a store by the manager or merchant. The youth is very helpless in defending himself against this labeling process. He has no power or credibility to challenge those who have affixed a stigmatizing label on him.[1]

The second factor which seems to increase the problems of the delinquent youth in the rural area is that the familial system lacks the ability to cope or effectively deal with the problems of these youths. The family has had a limited understanding of their child's behavior, and therefore has had a tendency to react intolerantly and authoritatively towards these problems. The parents will initially try to resolve their child's truancy problem, or delinquent behavior, or any normal developmental problem, but will lack the ability to consistently control or stay on top of the situation. They generally lack the time, energy, and knowledge, largely because they are burdened with other problems which typically have a higher incidence in rural areas;

such as alcoholism, inadequate education, unemployment, divorce and marital problems, and low incomes. A parent, for example, will be preoccupied with his own personal problem and struggling to make ends meet. The child's problem merely represents another burden or crisis. These parents traditionally may try and resolve the problem by taking something away from their child, or by threatening to have them sent away to the boys home or a State institution. They may also request that their son not associate with his best friend whom they feel is a bad influence. The child resents such a parental response, because his friend is of primary importance to him. The parents may also respond in a defensive or over protective manner when a school official or law official identifies a problem with their child. They view the intervention from a social worker, a teacher, a policeman, or the court as very threatening. They feel they are being blamed for their child's behavior, and to them it can only represent another failure. The results are: (1) the parents are often very erratic or inconsistent in responding towards their child's developmental needs and/or in trying to impose appropriate sanctions for their child's behavior. Once the initial crisis subsides for the child the parents will again turn to deal with their own problems. (2) The parents will lack the willingness to cooperate with the schools or a social agency. They will likely go through the motions of the agency's case plan, and subtly sabotage change efforts.

The third factor which appears to contribute to delinquency is the rural school's response towards these youth and their problems. They are often unable to deal with school failure which develops in the early elementary grades. It is typical to examine the school record of a delinquent youth and discover that he has been failing and has poor attendance since fourth grade. The problem is that the delinquent youth doesn't fit in a special educational program, though he needs more to motivate him than a regular classroom. The school board members don't appear ready to finance an alternative education program like many larger cities. The reasons seem to be: (1) the rural school doesn't have as many numbers who could benefit from an alternative education program, comparably to an urban area, and (2) the school board members presently don't appear willing to finance a program for the long-haired, goof-off, or undeserving kid. It further seems that the schools are having a difficult time in knowing how to confront the problems. They are unsure of

how much responsibility they have towards resolving failures in school. They typically understand school failure as resulting inherently from the family. This is true, particularly with low income families. The problem is the schools often neglect to understand how they are contributing to the situation.

The rural school system like urban schools shows a definite pattern of responses towards a student's acting out behavior, incompletion of assignments and poor attendance. The schools in our area deal with these problems by imposing an increasing amount of restrictive measures on a student. A principal, for example, will detain a student after school for skipping a class, or smoking a cigarette in the hallway. The youth will probably abide by the principal's disciplinary actions for a short time, but will soon develop a feeling that it is not worth it anymore. The youth who has limited success will soon come to the realization that there is no payoff in following the school rules and guidelines. The student who is repeatedly blamed for his negative behavior, and who rebels against the school's sanctions will make himself more visible to the principal, the teachers and the school secretaries. An increasing number of complaints will probably surface towards this student, and in actuality the complaints will likely become more petty and insignificant. The youth will be blamed more often for things he didn't do, because of his past association with other problems. It becomes a very demeaning process for the youth and he will have greater difficulty in concentrating on normal school activities. The youth may withdraw or react very defensively towards each additional accusation. He will probably begin to demonstrate a poorer attitude in his classes and begin to frequently skip his classes or not show up for school. The labeling process will eventually lock the youth out of the system, and the youth will have no other alternative but to drop out of school.

A social worker who delivers services to the delinquent youth in the rural area finds that, "you are your own best resource." One essential reason is that the social worker holds the only position within the county that deals directly with the delinquent youth. This leaves a considerable amount of power and responsibility with one person. The way Waushara County's Juvenile Court functions, for example, increases the social worker's responsibility in making appropriate decisions for the lives of these children. The court can be described as participating in a rather passive manner throughout the juvenile court process. The Judge, for example, will consistently follow

the social worker's recommendations regarding the disposition for a child alleged to be delinquent, "in need of supervision," or dependent. The social worker also has a considerable amount of autonomy in deciding when to terminate or to continue with a case. Furthermore, the county's district attorney has limited time to devote to local juvenile court matters, partially because the position is only half-time. The social worker, for example, will wait from one to three months before this office completes a juvenile court petition. A result of these factors is that there is a limited degree of checks and balances within this court process. The court's disposition, for example, shouldn't solely be based on one worker's perspective or recommendations. The social worker who works within such a system is left in a rather vulnerable and liable position. It is therefore very important for the worker to safeguard against such things by careful documentation of the court's investigations.

Another important aspect, is that it often seems that the people in the community maintain a stigma towards the role of the social worker. The worker, for example, will generally receive limited cooperation from community people for the client, because the delinquent and his family will usually maintain low status and influence within the community. It seems that people will dismiss any responsibility for a youth once he is placed under juvenile court supervision. This is significant because if the social agency doesn't support a child's development or pursue a particular case, it is likely that no one else will either.

One important aspect of, "you are your own best resource," is that there are a limited amount of recources to bear upon these problems. One major deficiency is that the rural community has limited programs or opportunities for a youth to be able to use his time in a constructive and meaningful manner. The youth, for example, has no recreational program to attend during the evenings and after school. The youth could attend the school's traditional activities and functions, except the delinquent youth is typically resistant to the school's rules and supervision at these activities. The lack of employment opportunities for our local youth is further limited. There is some seasonal work with local farmers, or a few openings with the youth work experience program, but generally there aren't many opportunities for steady full-time or part-time employment. The amount of idle time a youth has certainly

seems to have a bearing on the fact that many of our referrals are for drinking alcohol or smoking marijuana. It also seems to contribute to the problems of the delinquent youth who drops out of school and is not able to find employment.

Another gap within local resources is that the social agency is unable to find a temporary placement for a child who has runaway from home or is in need of a rest or "out" period away from home. The agency traditionally has placed a child in detention or the county jail or has sent the child back home to his parents. The first option is usually unnecessary and inappropriate for the child who is in need of supportive environment, rather than the isolation of the county jail. In 1975 there were 29 children who were placed in detention, and of this number, 18 or 62 percent could have benefited from an alterantive placement. In the latter incident when the child is sent back home it seems that we are sending the child into a revolving door. In 1975 it was estimated that 82 children or 35 percent of a total of 318 children who came in contact with our agency and the Sheriff's Department could have benefited from an alternative placement. In the past we were occasionally able to place a child in a foster home. These placements are rare since many foster parents do not want the adolescent youth in their homes, and also because the agency is hesitant to make such a placement since the agency usually knows very little about the youth. When all else fails it is not atypical for a member of the social work staff to take the youth into their own homes. In the near future, the agency hopes to be better able to deal with these situations. Waushara County Department of Social Services is in the process of securing funds to develop a temporary placement or a sheltered home facility. The significant aspect of this project is that it is a joint venture with two other adjacent counties. This joint effort is necessary to be able to demonstrate a large enough need, and to be able to financially support such a project.

The Department of Social Service's traditional casework approach to the delinquent youth and his family is basically the most well developed resource or method for handling these problems. Still, this approach is often inadequate in bringing about significant amounts of change within the youth's present surroundings. This inadequacy is evident by high recidivism of those juveniles who come in contact with law officials and the juvenile court, and also by the high number of youths who are committed to state institutions.

In the latter instances, there were 11 youths in 1974 from Waushara County that served in correctional institutions. This was .3 percent of the county's juvenile population. Waushara County ranked 10.5 within the state on a high to low scale. In 1975 there were nine youths that served in a state correctional institution.

In approaching these problems as a social worker, one has a tendency to become overwhelmed in the continual struggle of providing resources, in the communities' intolerance to clients, and of the degree of problems within the social system. A key point towards overcoming these helpless feelings is to recognize that the social worker's major responsibility is to identify each problem within the context of the total situation, and to provide the necessary feedback to these social systems so they may learn to understand how they are contributing to the problem. The agency is essentially shifting the burden of the problem or the responsibility to the youth and his surroundings. The worker's objective is to help these social systems to develop new approaches, or coping strength, in responding to these problems. There are still going to be many drawbacks or little success on a case by case basis. The focus is, however, to help people react to the causes of their problems and not the traditional reaction to the symptoms of the problems.

In working with the alienated youth within his family there is a basic need to play an advocate role in bringing out the youth's feelings. The parents need to understand the normal developmental stages of their child and to recognize that their child is still a good person, despite his bad behavior. The worker's objective is at least to reduce the parents' intolerant feelings towards their child, and if possible, to redevelop a trusting relationship between them. An example of this process can be demonstrated when a child is found in possession of marijuana. The parents' reaction typically has a tendency to create more problems than does the child's actual drug use. The parents will usually hold many fallacies about the use of marijuana. It becomes necessary to provide the family with a rather instructive role in discussing the physical and psychological effects of the drug. The worker should attempt to help bring out the child's attitude about the use of the drug as well as the reasons that lead up to the actual drug use. In this particular example, the youth may even continue to smoke pot, but the worker could have desensitized the parents, so they may respond to their child in a non-

threatening way.

The parents who erratically discipline their child need some education in parenting techniques. They must learn to recognize that they cannot expect their child to change unless they respond appropriately towards him. The worker can suggest appropriate consequences for the youth's negative behavior. This usually is needed because in the past the youth has not responded to the parents' threats, which in most cases have been unreasonable or unenforceable. In view of parental inconsistency it is necessary for the worker to follow up with the parents to insure that the parents do not lose sight of their responsibility. The implementation of a behavior management program for the parent and their child can often be an effective method of dealing with these issues.

In intervening within many families the worker will often find it impractical to maintain the focus of services solely on the child's problem. It is likely that another child within the family will be experiencing other problems or that the parents will have their own personal problems which have a definite bearing upon their children. The worker will likely have to expand the scope of the intervening to other members of the family because: (1) it is impractical to refer each case to the local mental health clinic in a rural area, and (2) the worker is the most accessible to the problems. A mother and father of a client for example, are experiencing serious problems within their marriage. The worker was unsuccessful in providing linkage to the county's marriage counselor, because the husband refused to cooperate or face his marriage problems. The worker may continue to stay involved with this problem by helping the mother cope with the situation.

Waushara County Department of Social Services has traditionally limited intervention with the County's local schools. The agency needs to improve its casework efforts with local schools, as well as pursue more formal cooperation with these schools on a class action basis. This means the agency needs to maintain ongoing communications with the principal and teachers within the schools over the client's progress and further develop a method where personnel from the county's school system, social agency, mental health agency, and law enforcement agency can meet and exchange ideas about these problems. In intervening on a casework basis with the local schools, the worker most often finds himself in an advocate role. This is demonstrated by the following objectives that a worker can typically become involved with. (1) There is a

definite need to set up an opportunity for the youth to be able to express his feelings about a particular problem situation. If a youth, for example, has been in past trouble at school he typically will have limited opportunities to be able to tell his side of the story. (2) The worker can suggest less authoritative methods of discipline for a client's negative behavior. The objective is to maintain the client's respect for the school's authority, and to hold the youth within the system, rather than locking the youth out. A client, for example, who repeatedly disrupts a teacher's classroom could typically be suspended after repeated warning. It might be more appropriate for the school to take the youth out of the particular class instead of giving him a three day vacation. (3) A network of communication needs to be established and pursued by the worker, so that both the school and the social agency are not operating within a vacuum. The purpose is to provide one another with enough information to reduce the likelihood that any distorted perceptions will develop towards a particular youth. This may, for example, be accomplished by a worker-teacher conference or by staffing the case with the client's teachers, the counselor, or other significant people within the school. These conferences could also provide these people an opportunity to ventilate any hostile feelings, therefore lessening the chance that they be directed to the student. (4) The worker needs to assure that the client is receiving an educational program that is appropriate for his psychological and physical condition. This could, for example, mean that the worker provides linkage for the client to the school psychologist for the purpose of evaluation. A further example, is that the worker could intervene to assure that a high school girl who becomes pregnant has been given the options to chose between homebound instruction or remaining in school. (5) The last objective is to assure that the school has not neglected to refer a truancy problem or any other matter that should appropriately be handled within the jurisdiction of the juvenile court. In some instances, for example, a local school will neglect to refer a truancy problem to the court, because the student is age 15½ or almost old enough to quit. The school may also neglect to refer a truancy problem until the latter part of the school year, when it should have been referred after it first developed in the beginning of the year. In another instance, the school should definitively refer a case when the child's parents are significantly contributing to their child's truancy problem. This is particularly necessary for a younger child who is being kept away from

school, because of the social needs of the mother.

There is a definite need for local county officials to begin to meet and discuss broader issues related to these problemed youth. The group should have some representation from all the professionals within the community who are directly or indirectly involved with these problems. An initial goal for the group is to develop an objective understanding of these problems, and to determine what they want to do about them. Professional members from our schools, social agencies, and the Sheriff's Department, for example, began to discuss common problems during the 1975-76 school year. The ad hoc group limited progress throughout last year, largely because it was unable to clarify the focus of the group. In the future the group could be utilized to address some of the following tasks. (1) There is a need to identify and document the problem areas which need attention. This, for example, could mean documenting the school's drop out rate, or detecting those children who are beginning to fail in the elementary grades. (2) There is a need to develop an understanding of how local agencies and schools respond towards these problems, and how professionals can more effectively deal with these problems. This, for example, could mean studying the school's pattern of responses in disciplining or motivating these youths. The development of a model for the interrelationships of schools and the social agencies could also be beneficial in clarifying such things as when it is necessary to refer a case to juvenile court or whether a social worker should intervene into the client's school situation.

In conclusion, a worker must be careful not to over identify with the needs and feelings of the delinquent youth in the rural area. The youth who is perpetually complaining about how everyone is against him often pushes the worker into a rather over protective role. The worker can safeguard against such a problem by working within the youth's total surroundings. In essence, the social worker must help others react to the causes of a child's delinquent behavior, rather than the symptoms.

FOOTNOTE

[1]Robert W. Winslow, *Juvenile Delinquency in a Free Society* 2nd Edition, 1968, page 95.

THE RUNAWAY YOUTH ISSUE: IMPLICATIONS FOR RURAL COMMUNITIES

Kenneth Libertoff

The central purpose of this paper is to provide a clearer and more accurate perspective for understanding the runaway youth issue. Although this problem has often been identified as an urban phenomenon, in no small way a reflection of the well publicized "flower years" of the 1960's, there is little doubt that many rural adolescents partake in this behavior. Recent national trends have indicated that runaway children are no longer heading for urban centers but choose instead to stay much closer to home. Since the United States Subcommittee on Juvenile Delinquency has estimated that the annual number of runaway children may be as high as one million, this issue should be of great interest and concern to professionals in the human services fold.

Because workers in rural communities have had little or no experience in meeting the needs of runaway children, this paper will also describe the development of one innovative model for working with these youths in a country setting. This program, aptly named "Country Roads," is now being implemented by the Washington County Youth Service Bureau in central Vermont.

An Overview

Although some experts believe that "running away" is of recent vintage, runaway children were among the earliest immigrants to the eastern shores of this nation. There is little doubt that the runaway child was a familiar person in the settlement and development of the original thirteen colonies. Running away to America, and more significantly, running away while in America, has traditionally grown out of a mixture of youthful expectations and hope for a better life away from home as well as out of frustrations and despair over current life circumstances.

Running away to this country was in fact part and parcel of the founding of this nation. There is much evidence to suggest that the runaway child in America has played an important role in the growth and development of this country. There are numerous accounts of many young and daring teenagers who

left home in quest of a better life. Not surprisingly, some of these youths were to become America's greatest heroes. Benjamin Franklin offers an excellent example of how a spirited nature, a desire for travel and the need to assert personal independence led to an important runaway experience. Of course, running away was not confined to urban locations or even to more populated sections of the country. The history of rural America is filled with runaway episodes. The frontier was often explored and settled by youths like Davy Crockett who ran away at age thirteen from his frontier Tennessee home in order to escape a harsh father and to travel in the western wilderness.

Many public officials and private citizens have, over the years, expressed bewilderment over the fluctuating but continuous occurence of this behavior. Yet a careful analysis of historical facts establishes that periods of social change and stress have always increased the incidence rate of runaway behavior. This has been true during every American war, during periods of great economic turmoil and during times of cultural or social exploration.

The counter-cultural youth movement of the 1960's is probably the best example of the latter variable. Running away to Harvard Square in Cambridge, Greenwich Village in New York and Haight-Ashbury in San Francisco became a publicized "happening." Many, perhaps even a majority of these youths were from comfortable middle and upper-class families. When the runaway youth issue reached "middle America," often through the pages of Life, Time and Newsweek magazines, it became an issue of considerable attention and concern. The creation of the first "runaway houses" in the late 1960's and the passage of the Runaway Youth Act of 1974 are but two indicators of keen interest.

The Literature

There appear to be few issues of current interest and importance, not to mention historical persistance that have such a sparse and contradictory body of literature. There are three pronounced viewpoints that run through the literature. The first significant opinion is that running away is evidence of individual psychopathology. This segment of the literature most often defines the runaway child as disturbed, impulsive, disorganized and/or delinquent (Jenkins, 1971). A second perception, while not necessarily refuting the former position ascribes situational external forces such as family or school pressures as causative (or contributing) factors responsible for

such behavior (Outland, 1938). A third and perhaps more contemporary theoretical assumption is that running away may be a natural outgrowth of certain predictable societal forces and may represent for some adolescents, a healthy self-actualizing and growth producing activity (Libertoff, 1976).

There has been and continues to be a propensity to overlook several important variables that have affected if not actually defined the nature and scope of knowledge about runaway youth. While it is always beneficial to be concerned with organizing and synthesizing what is known about a subject, it may be just as necessary to identify and analyze that which is unknown or that which has not yet been investigated. These deficiencies or gaps in knowledge also can be instructive as part of the process of forming a framework for understanding the broader dimensions of the runaway phenomenon. There is reason to believe that the existing body of literature is more reflective of and informative about the types of social networks that have interacted with this population of young people as well as the professional training and field setting of the researcher, than it is about the actual subject under consideration.

Almost by definition, running away is an enigma for those who seek to investigate and study this behavior. Those who "leave home prematurely" are generally transient, often escaping from home or heading to some new or alternative destination. Because of many adverse legal sanctions, most young people on the run are reluctant, or at least hesitant to communicate or interact with traditional social settings. It is not surprising therefore, to find that there is a good deal of uncertainty about the exact number of adolescents who partake in this activity from year to year (Brennan et.al., 1975). Information about runaway behavior has come from investigations in urban, suburban and university communities. There has been little, if any, recognition of the runaway child in American rural communities.

Social Networks

Much of what is known about runaway children is a direct reflection of the type and kind of agency that has, over the years, maintained responsibility for this population. That is to say that many runaway youths have been controlled, treated and/or served by a number of agencies which comprise several particular social networks. A careful reading of the literature suggests

that knowledge about this phenomenon has been derived from four networks. These are identified as the *police-legal network*, the *mental health network*, the *social welfare network*, and the *self help youth-advocacy network*. Two additional networks should also be categorized although to this date there is almost no literature or information about either of them. They are designated as the *"helping peer-adult network,"* and the *"no network"* pattern of interaction.

POLICE-LEGAL NETWORK

Young people under eighteen years of age who run away, that is, who leave home without parental permission, have been and generally still are considered lawbreakers in this country. The precise legal statutes in many states have been vague and unclear (Beaser, 1975). A warrant by a parent or the issuing of a stubborn or wayward child charge has frequently been sufficient for arresting and incarcerating a runaway child. Simply being away from home has made a young person vulnerable to legal sanctions while citizens who offer shelter to these youths are also in violation of the law. Despite recent efforts to de-criminalize these laws in many states throughout the country, many young runaways are still adjudicated within the police-correctional network (Andrew and Cohn, 1974). As in the past, juvenile courts, probation departments and reformatories still play a significant role in controlling these youths.

MENTAL HEALTH

In more recent decades, the mental health profession has become an important helping service as well as an influencial treatment and controlling agent (Goldenberg, 1971). Psychiatrists and clinical psychologists have been involved in juvenile court clinics and child guidance centers. These clinicians have devoted much time to examining and diagnosing, not to mention treating, young people who have run away. Although there is considerable controversy and difference of opinion regarding the cause and meaning of runaway behavior, the American Psychiatric Association has officially categorized running away as a mental disorder. (Jenkins, 1971).

SOCIAL WELFARE NETWORK

Since the late nineteenth century when social reformers helped to create special judicial procedures and correctional institutions for youthful offenders, a development that lead to the creation of the juvenile justice system, runaway children have been a concern to many social service agencies (Nyquist, 1960). The Traveler's Aid Society, the Young Men's and Women's Catholic Association, settlement houses and various community emergency shelters are but a few of the social welfare agencies that have worked with runaway youths since the turn of the century.

SELF-HELP

The self-help youth advocacy network is a product of the past decade (Gordon, 1974). Growing out of the anti-poverty efforts of the 1960's as well as the turbulent anti-war movement, this network represents a group of individuals who have, for the most part, rejected much of the professionalism of the clinician and the delinquency labeling of the police-correctional network. While lacking a precise ideology, most youth advocates view juveniles as powerless victims of an unjust and uncaring society. Therefore much effort is given to helping young people gain control over their own lives. Workers in this network are frequently non-professionals who place much emphasis on giving assistance to those young people who voluntarily request it. Because self-help workers, particularly those involved with runaway programs, have been primarily concerned with providing services, relatively little has been written about the interaction of runaway children and this network.

PEER-ADULT NETWORK

The first of the two less formal and recognizable networks is the helping peer-adult network. Many children who run away turn to their friends or peers for support and assistance. Runaway youths often communicate with a friend's parent, frequently a trusted and caring figure. In many cases, a peer of helping adult provide the first alternative shelter for a child who has departed from home. Helping peers and adults may also be total strangers. While for the most part this interaction is voluntary and supportive, some of these helping figures are neither benevolent or kind. Little is known about this network or its patterns of interaction.

NO NETWORK

The last network carries the ironic title of "no network." It covers the experience of those youths who manage to leave home and not interact with any of the forementioned networks. In some context, these adolescents can be considered "successful runaways" in that they leave home and manage independently without any formal network interaction. There is no literature and very little recognition of these youths although their numbers may be considerable.

In order to further explore and analyze the meaning of past research endeavors in the field, it is useful to examine, in greater detail, some of the implications and ramifications of the interaction between those who have studied "runaway youth populations" and those who have participated in this behavior. As previously mentioned, young people who run away are hard to find or locate. This simple fact poses special problems for those professionals who seek to study these young people. Not surprisingly then, much of the previous knowledge in the field is from settings, primarily those in the police-legal

network and mental health network, in which most runaways tend to be captured, controlled and treated on an involuntary basis.

During the past fifty years, much of what has been written about the "runaway child" reflects research and investigation within the domain of the police-legal network, especially in detention homes, correctional institutions and court clinics. Since running away be definition has been categorized as a law breaking activity, the very process of entering this network is a stigmatizing one in which runaway adolescents are, at the very least, labeled as juvenile delinquents and troubled youths.

The mental health network, particularly the child guidance clinic, has historically been a major point of interaction between those who run away and those who study this behavior. Mental health professionals, most noticeably psychiatrists and psychologists, have been responsible for the diagnoses and treatment of these young people who are thought to be exhibiting deviant behavior patterns. These clinicians have exhibited a tendency to focus on the intrapsychic dynamics of the young person's behavior, frequently ignoring the psychosocial variables. Within the framework of their training, many of these professionals have, over the years, often concluded that running away is a psychopathological disorder and mental illness.

Developing a Rural Program

In 1974, Congress approved and the President signed the Runaway Youth Act. This piece of legislation marked the first federal response to the runaway youth issue. During the first several years of funding, urban, suburban and university communities received support for programs, most of which took the form of "runaway houses." These facilities most frequently offered short-term residential care for anywhere from five to fifteen youths. A staff of four to eight members, often recent college graduates, maintained these projects on a twenty-four hour, seven day a week basis.

By the early months of 1976, staff members of the Washington County Youth Service Bureau, a private non-profit organization in rural Vermont, were becoming increasingly aware and concerned about young people who were leaving home prematurely. On a regular basis, workers were being contacted and called upon to assist youthful runaways and transients. Some of these children were having

great difficulty in getting along with their families; others were faced with physical or psychological abuse, school problems, unwanted pregnancies and extreme poverty. The Bureau, the County's only major youth serving agency, found that it was not able to adequately meet the special needs of these young people.

Staff members at the Bureau carefully considered several crucial variables in the process of designing an appropriate runaway program for a rural environment. They were:

Assessment of Needs: Relative to urban communities and states, Vermont does not collect or maintain adequate data on youth needs and problems. The Youth Bureau therefore had to develop its own needs assessment plan.

Geographical Scope: The Bureau is responsible for all youth programs throughout a large rural county in central Vermont. The staff was eager to include all sections of this area in the model program.

Counseling Modalities: Because running away was viewed as a family dynamic, the Bureau was committed to working with teenagers and family members. This strategy called for some unique counseling approaches.

Community Acceptance: Vermonters pride themselves on being simple, independent and reserved people. A general resistance to change often makes the introduction of a new project quite difficult.

Financial Support: Vermont is a poor state with limited local resources. Yet the Bureau was committed to operating a quality program which included residential care, medical services and constant availability.

Country Roads

After staff members considered and studied each of the previously mentioned issues, the Youth Bureau developed a runaway program called "Country Roads." This project has several unique attributes. It is the first rural program to be funded by the Office of Youth Development (HEW) which is administering the Runaway Youth Act. Country Roads is also one of the very few projects that is closely allied to the "helping peer-adult network," a network about which little is known.

The project evolves around the concept of creating a "network of supportive, helping families" within the central Vermont region. These families will house and work with runaway teenagers, providing shelter, food and general

support during a one day to three month period. The Bureau's runaway youth project coordinator will provide constant training and guidance to these families and also develop a peer counseling program with the runaway youths. The coordinator will maintain the primary responsiblity for working with the runaway child's family. While the primary aim of the project is to have young children return home, when that is not possible, new alternatives will be developed.

Country Roads has several other important goals. The first is to provide a safe, temporary but supportive shelter for children away from home in a rural setting. The creation of alternative living situations is an important priority in rural environments. As a second expectation, Country Roads will encourage the idea of family participation in local neighborhoods. These helping families should provide a new community resource in rural areas where local provincialism, limited resources and geographical distances often inhibit the delivery of needed human services. A third and no less important goal is to encourage rural children and their families to seek out assistance before problems reach the crisis state. Obviously, prevention strategies are as important in country areas as they are in large, urban locations.

Summary

There is a great need to narrow the existing gap of knowledge and understanding concerning runaway children. Being neither a creation of the turbulent 1960's nor a minor passing fad, the issue of runaway adolescents in our society is now, and will continue to be a major concern for years to come. Presently, our society often labels runaway children as psychopathological or delinquent (or perhaps both). Yet there is much evidence to challenge and refute these assumptions.

Reviewing the history of and the literature about the runaway child in America reveals that young people from poor families have always viewed running away as a reasonable way of leaving a poverty-stricken home. For many adolescents, running away has been a response to an unhealthy family or work situation, and at times it has been a problem-solving behavior. Since early colonial days, running away has been synonymous with seeking adventure, romance and one's fortune. Last but not least, running away has been an expression of independence, often marking a passage into adulthood. Periods of great social,

economic, cultural and political change have always fostered runaway behavior, and periods of war have also contributed to this syndrome.

Although running away has been projected as an urban experience, there is growing evidence that rural communities are also in need of services for these youths. There is a concern however, that rural human service workers will simply replicate urban programs as federal support becomes available. Programs like Country Roads in Vermont should help reinforce the notion that human service workers must develop appropriate models that are relevant to the special conditions and needs of rural environments.

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3 SERVICES TO THE RURAL ELDERLY

It is no secret that the population of rural America is overly disproportioned in terms of the aged. The following three papers by practitioners address innovative programming in rural Wisconsin to improve the quality of life for the growing elderly population.

PRESERVING THE DIGNITY OF THE ELDERLY IN A RURAL AREA

Rosemary Bohart

After World War II, it was recognized that this country was developing a sizeable population of older people with special problems and interests, and if something was not done about it we would have a serious crisis on our hands. According to George Sunderland, with the AARP (American Association of Retired Persons), there were 21 million Americans over 65 years of age in 1974; there were 42 million persons 55 years of age or over, and by the year 2000 it is projected that in excess of half our population will be over the age of 55.

Science, economics, and the social advance of this century have increased the life span of the elderly, but they are compounded with a multitude of problems forced upon them by a changing society. Our mobile society has caused many of the problems for our older Americans - social isolation, and detachment from family and community ties that are important in later years. Several studies have been done, and as a result we have better Social Security Programs and better pension plans with which individuals can through their own devices build a greater security in retirement. Money is important, but it does not solve all the problems of the elderly.

The traditional roles and structure of the family have changed. The elderly are no longer needed for the wisdom and advice of their experiences; they are no longer needed in caring for the young. In fact, many of them see very little of their grandchildren. Their incomes are fixed and low, and they are especially vulnerable to the effects of inflation. Their medical care tends to be long-term and expensive. Most aged persons live in their own homes, and as they grow older many require changes in living arrangements, hence, increasing their dependency on others. To most older Ameicans independence is valued almost as much as life itself; it is their self-respect and dignity. They feel unwanted and rejected. They have a desire to be useful, but employment opportunities are limited. Some have restricted mobility and lack transportation. There is a loss of identity, income, health and loved ones. Loneliness, loss of status, alienation and segregation from community life are prevalent. The solutions to problems of the elderly must be shared by all levels of government,

private organizations, and individuals.

The older adults are in the process of withdrawing from the things that were important in their life - they retire from work; they take a less active role in family matters; they go to church less often, and their travels are less and limited. They have to re-define and re-evaluate their self-worth and find new satisfactions that are available to them. We need to be aware of the feelings of the older person and the changes that are taking place in their lives, and we need to provide the assistance to help them in making their adjustments to these changes. It is important that we understand the aging process as a biological, psychological, and social phenomenon. We must have compassion and understanding of the elderly in relation to their potentials, status, and their functions in society; and to the feelings of the aged toward service organizations, institutions and agencies.

For the most part, problems of the elderly are virtually the same be it a rural area or an urban area, but the people and their values are different. The needs and wants of the elderly in a rural community are very simple, but providing the services is more complex. We find that being able to remain in one's own home and have social contacts are the two most important needs of the elderly. Most of the elderly were born in the county, and will die in the county. They are of a generation of hard work, thrift, home ownership, and independence. Their recreation was family, friends, and neighbors, and they met each others needs. These are values we have to deal with in providing services. We must assess the individuals needs very carefully and replace what is lost in the aging process with services that will not go against their values, so that the person can continue on with his life style and retain his dignity and his self-respect. We must know the status of the individual's health, recognize their strengths and limitations and work with these. We must let them do the things they are able to do for themselves. We must encourage family involvement, and recruit "friendly visitors" from the community to replace the friends and neighbors who become fewer with each passing year.

We must have a good understanding of the values of the community and the community and the people if we are to provide effective services. We can spin our wheels and become very frustrated if we do not start where the client is. It is useless to force our values on others. The elderly are going to bo doing things very much like they have always done them, only to a lesser degree with

the declining years. If they have been highly motivated and active during their lifetime they will continue to seek social contacts and find things to do. If they have led a very sedentary type of life, this is what they will continue to do no matter how much we try to force them into activities. Looking at it from this standpoint, if the elderly person has been very active and things suddenly come to a halt because of limited mobility and lack of transportation, then we must bring socialization to them. We can accomplish this with our service workers and our volunteers. In coordinating our services to these individuals they are arranged so that each individual delivering a service will be there on a different day. The workers take time to sit and talk and listen, and do those extra little things that can mean so much. The services do not exhaust the individuals; they help to maintain relationships and prevent loneliness - there is someone and something to look forward to two or three times per week. Loneliness is a result of being isolated from friends and relatives not a result of living alone. Most people enjoy the freedom and the privacy that comes with living alone - especially women. We must provide transportation for shopping, medical appointments, church, and senior gatherings. If the individual is of the sedentary type, then we should help them in doing the things that they can do that are important to them. Perhaps, we can supply them with books, magazines, puzzles, or just supply them with an outlet to sell their knitting, crocheting, or jewelry making.

Working in a small rural agency calls for self-motivation and self-direction. We are alone in what we are doing, and we are responsible for our actions. We must be creative and imaginative. We must be able to coordinate our services in a variety of ways to produce a variety of results. We must be able to recognize and understand the service delivery system of a community and utilize these sources in our services to the elderly. For example, if individuals are being looked after by relatives, friends, neighbors, and the church, we should incorporate the services that only we can provide and encourage the existing support. To many of the elderly public assistance creates a sense of worthlessness and, therefore, a loss of dignity. As individuals progress into old age there are many crises that come up that they cannot handle by themselves, and if there is no family or friends to turn to, they may be forced to accept public assistance. We must provide the needed services with integrity so that the individuals can retain their self-respect and dignity.

We believe we can give more personal and informal services being small and being rural. Our caseloads are smaller than urban areas, and we can be more things to more people. We are advocates, advisors, consultants, counselors, facilitators, instructors, coordinators, recruiters, diagnostitians, evaluators, assessors, chauffeurs, arbitrators, and much more, but most of all we are friends in a time of, "need-someone who cares." We get to know the elderly and their families better by seeing them function in the community, and at the same time they get to know us better by our involvement in the community. Rural communities are suspicious of outsiders; we have to prove ourselves before we can be of service. Many people think that "Social Services" are continually checking on them; that we take liens on their property, and that only lazy people are on public assistance. We try to counteract these negative feelings about "Social Services" with speaking engagements at senior gatherings informing them of our services, and that as citizens who have paid taxes all their lives they are entitled to these services. We have a weekly newspaper column with factual information on our services and the myths of the Welfare Program. Workers must be able to converse about things that are important to the individuals such as the weather, gardening, canning and preserving foods, their homes and families, or about the community and the county, thus, we are creating better client relationships.

It is imperative that a worker know the community and the resources that are available, and that the agency have good communications and working relationships with these resources; it facilitates our getting the assistance and the information we need to carry out our service plans, and it helps to develop a closer knit team-work approach in working with our clients.

We have an adequate amount of service in our county to keep the elderly in their homes as long as possible. We utilize the supportive services we have and work on things we can change to improve our services. Services, of course, vary according to the individuals; they are always changing, and they come from a variety of sources. The primary concern of the elderly is their health, to maintain their independence and remain in their own homes. Most of our services are health related, such as the homemaker who may go into the home or prepare meals to be heated up or to be frozen for future use; the housekeeper who goes in to do the cleaning that the elderly cannot do for themselves; or the money payments that are available to a relative or the

individuals themselves for personal care. Also, appropriate referrals are made to specialized sources such as the County Health Department, the Guidance Clinic, and the 51.42 Board.

The elderly must be assured of enough income to meet their needs and to participate in community life if they want to. We must be abel to assess their financial needs and if necessary seek outside resources to increase their income. Perhaps, they may be referred to Income Maintenance for Food Stamps and Medical Assistance or to Social Security for Supplemental Social Security Income. We also encourage "people helping people." Most of the elderly who are not disabled can use their talents or skills in exchange for the skills of someone else. Helping others serves many purposes; it makes the individual that is doing the helping feel useful and needed; it increases their income, and they are providing a much needed service. Most of our Volunteer Drivers are senior citizens themselves.

Most elderly people are money conscious; thrift is an inherent characteristic whether it works to their advantage or not. They may deprive themselves of many needed things such as certain food items because they are too expensive or recreation because they consider it a luxury - something they can get along without. Participating in community life is very important to many people, but everything costs money. They stay away from churches because they are always wanting money. The elderly want to pay their share, but they find that they cannot afford to pledge the amount the church is asking, and rather than be embarrassed they do not participate. Some churches go so far as to publish a list of who gave what. The one social institution in just about every community which could provide social contacts for the older people turns them off by continually asking for money. Many do not participate in the Senior Citizens Clubs, because they cannot afford to go on field trips or contribute money to have a full time director. These are two areas in our county in which a lot of public information work remains to be done. We need to involve the churches more, and we need more recreation of different types for the elderly.

We must intervene at times to protect the elderly from being exploited and abused by their fellowmen. In many instances, older people are completely ignored by our society, and even by their own families, yet at other times many commercial interests such as magazines, patent medicines, insurance companies and hearing aid companies exploit their fears of illness, loss of

abilities, and loneliness; others abuse services supplied to the elderly by government agencies.

We have many additional sources to call upon for supportive services such as CAP (Community Action Program); they provide minor repairs, winterize homes, and supplement fuel costs. The Commission on Aging coordinates many services to the elderly such as home delivered meals, a "hotline" service where individuals call other individuals at a certain time each day, and if there is no answer someone is notified to check it out. We both provide transportation with Volunteer Drivers; our agency services our clients and those on Medical Assistance and the Commission on Aging takes care of the others. The County Health Department loans out items such as hospital beds, wheelchairs, walkers, and many other items to clients who are unable to buy them. We utilize the Services to the Blind to get large print books and talking books for those who have lost their sight or have difficulty seeing.

When individuals can no longer remain in their own homes alone, because they forget to turn off the gas, or do not take their medications, perhaps a live-in attendant can be found to come into their home, or a "substitute care" home can be located - a home between the individual's home and the nursing home - where they can get the supervision they need, in a family living situation. We must continually keep in mind there are still many things the elderly can do for themselves and others. We must guard these rights and seek out things that they can do to still feel useful and needed.

Most of the elderly have a fear of going to a nursing home. They think of it as the "County Poor House" or "The Old Folks Home." Trips can be arranged for the elderly to tour nursing homes in the area, eat a meal there, and visit with the guests to let them judge for themselves whether or not they will like it instead of living in a fear of the unknown. Studies have shown that people in nursing homes are not nearly as unhappy as we are sometimes led to believe. Men, especially, are quite content. They may not be in their own homes, but they are taken care of; they are secure, and they have human contacts.

In delivering our services to the elderly we must be concerned about their social, psychological, and physical needs to enable them to function at their maximum capabilities. A key role that a worker with the aged must

fulfill is that of advocate. We must make known to the community and the agency the areas of unmet needs, and we must have the initiative to do something about them.

Why is it that at a time in a person's life when we are most needed, we desert them? Is it perhaps that we do not want to face up to the fact of life that we are all going to get old, and that we do not want to be confronted or reminded of it as if we could prolong the process; or is it that we are so self-centered and so wrapped up in our own affairs that we have no time for others? We always take time to come to the rescue in an emergency. Why can't we spend a little time more often to help prevent crises and bring a little joy into the life of an elderly person and let them know we care. Often times the only helping person to the elderly is the worker. We must accept the client as a human being on his terms and with his own set of values. We must involve the elderly in the solutions to their problems and plan with them. We must show patience, warmth, and interest. We must be equipped to provide personal and emotional support in the loss of loved ones, and, perhaps, we may be called on to help them overcome their fear of dying and prepare them for death with dignity as well as maintaining their dignity in life.

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ADULT FOSTER CARE - AN ALTERNATIVE TO NURSING HOME CARE IN MARATHON COUNTY

Walter Alwin

Definitions

Alternative living situations are defined as any living situation that takes the place of the original family setting and include such options as long term institutionalization, nursing home placement, communal living arrangements, and co-residential settings - to mention only a few. Adult foster care is a family based alternative to nursing home care for individuals who for one reason or another are not able totally to be independent, but who are ambulatory, self-sufficient as to eating and dressing, and do not need the professional services generally associated with nursing home care.

Adult foster care is nothing new. It is a time-tried pattern of dealing with individuals who are not able to live totally by themselves. At the turn of this century there were rest homes, as they were then called, which were just family homes that were usually run by elderly widows who took in neighbors who were not able to take care of themselves any more. These rest homes would be considered adult foster care homes according to our definition today. In the evolution of the modern nursing home these rest homes were the forerunners. In the 1950's and '60's there were still many large nursing homes that were still owned and managed by some of these old proprietors of the original rest homes. Rest homes were small in census with usually under ten guests and were loosely supervised by county and municipal welfare departments. Rates of care were negotiated locally and were generally reasonable. It was only after the enactment of Title XIX at the federal level that the big corporations came into the proprietary care picture in large numbers. And, of course, with federal programming, big numbers, and the needs for increased safety measures, the care rates rose astronomically and the nursing homes became big institutions and big business. Seen in this perspective, adult foster care is a return to an earlier American approach to the care of the elderly, infirm, and disabled. Of course, it must be remembered that these early rest homes came into being when the extended families no longer took care of their own elderly and disabled members.

Parenthetically, it is interesting to note that with the elimination of relative responsibility from the eligibility factors of welfare funding, that we are even returning to care and maintenance of the elderly and infirm by immediate family members who can now be funded out of social security or welfare funds. This almost brings to full circle the care of those who are not able to function totally on their own. In other words, in 1980 we may be coming back to where we were in 1880 with the help of welfare funding. Adult foster care, therefore, is a segment in the spectrum of alternatives for people who are not able to function totally independently - where independent is defined as being able to live alone or in a self-sufficient family unit.

In adult foster care, we use the terms "sponsor" for the providor of service and "guest" for the recipient of service.

From what has been stated so far, it can be seen that the raw outline of adult foster care is nothing new, but is something that has been practiced in American family life for a long time. Individual county welfare departments over the last decades have also been assisting financially in maintaining individuals in this type of family setting. In the late 1960's, however, the Wisconsin State Department of Social Services looked at various AFC programs and combined the best ideas from all of them, then issued a set of certification guidelines, which were meant not only to encourage the development of adult foster care programs, but also to give it some form of supervisory direction. Marathon County was one of the first to come into compliance with Wisconsin's new criteria and to implement them. The Marathon County Department of Social Services felt that here was a program that had broad appeal not only to clients, but also to taxpayers and citizens alike. The social service board with its fingers on the pulse of the community, was confident that the citizens of our county had not only the skill to implement the sponsorship of this program, but also the humanitarian dedication to make it successful. It seems that its expectations are vindictive at least at the end of the first three years.

Program Benefits

Benefits accruing to the sponsors in the AFC program seem to be twofold. The first is in the areaof relationships. Sponsorship cuts down loneliness. Indeed loneliness is a frightening, enervating state of being, and it is not

only surprising but even pathetic to see the appreciation in the elderly sponsor for what to you and me might be some pretty meager crumbs of a relationship.

For example, a sponsor in her seventies who had been a very active farm wife and who, after the loss of her husband and her eldest son, was living alone in her large farm home. Even her married children, who were very concerned for her welfare, found her a very difficult visitor in their homes. She was depressed; she was demanding; she was constantly picking on the grandchildren - in short, living with her was quite impossible. By chance she happened to see one of the agency's classified ads and applied for ceritification in our adult foster care program. The guest she chose was a young, 19 year old retarded girl from an extremely deprived background who had, and still has, numerous psychiatric problems. This has been one of our more difficult placements, and the problems have been numerous, as well as ongoing. At picnics or social gatherings, this guest had a habit of disappearing into the woods with almost any young man, much to the embarrassment of this devoutly religious grandmother. The young guest also has a vocabulary that would do justice to any seasoned stevedore and occasionally would lay a sample on the sponsor. She would steal from the sponsor's purse. The agency arranged staffings at the local (Mental) Health Care Center; the social worker would counsel with the girl and always it was suggested to the sponsor that she did not have to put up with this kind of behavior, and the the agency would move the guest immediately if this behavior continued. When the sponsor would respond that she felt that she could deal with the situation, that it was not necessary to move the young guest, the social worker was frankly perplexed. It was only after the agency met with repeated refusals to remove the young guest that the agency began to recognize that the sponsor was getting more out of the relationship than the agency could possibly have imagined.

This kind of situation develops many times - not in such an accentuated form - but, never-the-less, in terms of what most of us would define as an unrewarding, one-sided relationship. The response is very often the same. The elderly sponsors (the agency also has middle-aged and young sponsors, both single and families) would rather survive in a limited relationship than to be deprived of the contact with others altogether. It is certainly a commentary on our contemporary culture that this kind of loneliness exists. It

almost makes us feel that at times the agency is exploiting these elderly sponsors, except for the fact that there are no alternatives, such as different living situations, or outside activities, that hold out more appeal to these elderly sponsors. The adult foster care program with its seemingly limited offer of companionship is the life style that they elect.

The second benefit to the sponsor is economic. Many of our sponsors live on fixed incomes, and while they are relatively comfortable, the few extra dollars that are added to their monthly budget are in many cases very welcome. These few dollars may spell the difference between austerity and a more generous life style. To those of us who are able to buy a steak when we want one, it is perhaps difficult to imagine the delight that a few extra dollars in the budget can mean. To these sponsors, however, this extra income is very welcome. And who doesn't enjoy a steak more when it can be shared with someone else!

The advantages for the guest are also numerous, not the least being a greater mobility and independence as a result of being in a family setting. There is the feeling of not being just another number in a big institution but rather that of an individual in an intimate household setting. We all have seen the effects of long term institutionalization - the dazed, vacant stare; the aimless wandering down endless corridors; the queing-up for meals; the lining-up for baths. To see this procedure reversed; to witness a 68 year old man begin to talk and smile again; to see a 50 year old woman who has been institutionalized for 20 years begin (under the one-on-one tutelage of a friendly young couple) to sew her own dresses and take an active interest in the children - these are all rewarding experiences, and they are not at all unusual in our adult foster care unit. Over the past two and one half years, we have had many similar examples of guests who have had an astonishing reawakening of interest in life around them, in hobbies, in the animals of the farm, in the neighbors' children, in canning, cooking, and baking.

Last but not least are the financial benefits to the taxpayer. To be sure, he is pleased at the money saved. What with our rate schedule varying from a low of $155 a month to a maximum of $200 a month, it does not take a fancy computer to recognize that even our little program here in Marathon County is saving upwards of over a million dollars in tax monies per year when the cost of our program is compared to the extremely high cost of

institutionalization.

Goals in Adult Foster Care

One of the goals of adult foster care is to return guests to independent living in the community. Independent living, in terms defined by the program, includes return of the guest to his original private home or to his family. It also includes going into a new, independent living situation in an apartment or home, or in sharing an apartment or home with someone else. This latter case would be a situation in which there would be no supervision or, at most, follow-up case work and the assistance of a county social service homemaker for a specified period of time. Independent living is also defined as taking up residency in a half-way house. Also included in the total of those who went on to independent living are those guests who were married and then went on to establish their own homes.

Here is a breakdown of some figures. May, 1974, was the month in which detailed statistical accounting was adopted in Marathon County's adult foster care program. Prior to that time, the program in Marathon County was less formally organized and the statistical procedure was less clearly defined. Using the definitions for independence as outlined and looking at the 77 guests who left the adult foster care program in the past 27 months, the agency found that a total of 44 went on to independent living, while 33 left for other reasons. The greater majority of the 44 went on to some kind of independent living outside of their family or relatives and three were married. Of the remaining 33 guests who left adult foster care in this period from May, 1974, through August, 1976, 23 returned to an institutional form of living, at least for a period of time; six went to a private living arrangement very akin to adult foster care but without agency certification and supervision; and four died while in adult foster care. Of the 23 that were institutionalized, approximately half were placed in nursing homes because they were no longer able to provide for their own care and required nursing home care. The other half were returned for in-patient hospital care, usually for emotional problems. The progression from adult foster care to nursing homes is an anticipated and natural event on the spectrum of alternate care. Hospitalization for psychotic breaks is, in most instances, a temporary situation. When the acute emotional disturbance is allayed, the patient is ready for

discharge into another adult foster care home.

Reflecting on the various divisions of independent living, it can be seen that a wide range of choice and flexibility is available to the adult guest.

Another goal of the adult foster care program is long-term maintenance in the adult foster care setting. These guests are usually the elderly segment of the guest population who are not involved in any ongoing daily training or rehabilitation programs. They are the guests who will eventually be transferred to a nursing home, or they may die in the sponsor's home.

Another goal of the adult foster care program is the maintenance technique the agency calls "therapy through change." It was not always a goal. At first it looked like a problem. Only later did it change from a problem into a goal. One of the evolving facts of the program was the recognition that when all other forms of intervention seemed to fail, that often the guests could be maintained in the program and not be returned to an institution simply by moving him from one adult foster care home to another. At first, the staff felt that this kind of move should be chalked up as a defeat; however, as the agency wrestled with the problem, it recognized that everyone likes change and a vacation, so why shouldn't the guests also enjoy a change. So, from looking at the moving problem as a negative factor, the agency simply considers it one more management tool.

Sponsor Fatigue

There remains, however, one aspect of the adult foster care program that must be considered a problem, and that is sponsor fatigue. This, too, took time to diagnose. The agency was losing sponsors and there seemed to be good reasons for it. Reasons for discontinuing in the program would range from getting a new job, having relatives unexpectedly moving into the home, or retirement to Florida. When, however, the social worker noticed that these individuals who had dropped their sponsorship did not go on to the job they had indicated they were being hired for, were not using the room for that returning relative or were not retiring to Florida, the agency began to cast about for the genuine reason for their discontinuing in the program. It then became apparent that the sponsor was not willing to accept his fatigue or even recognize it as such, but would dodge behind an excuse (consciously or unconsciously);

and the social workers as professionals were not picking it up either. One must be alert to interpret the signs of sponsor fatigue, or it may be easy to accept at face value the reasons sponsors will give for discontinuing in the program.

The best way of dealing with sponsor fatigue seems to be to label it for what it is and be sure to mention it to new sponsors when they come into the program all fired up and with a bundle of energy. The social worker must tell them that they may get tired after a couple of years, that this is normal, and that when it occurs, the agency will recommend a rest, a sabbatical. There does not seem to be a set time for this running down on energy, because some sponsors seem to be able to go on forever while others tire during the first year. The important thing is to be aware of the syndrome.

Another solution to sponsor fatigue is part-time help. Our agency has recruited about one half dozen part-time sponsors. These individuals are ready to take over and help out for weekends and vacations. Often the sponsors recruit their own relief help from relatives, friends, or neighbors.

Recruitment

Recruitment is one of the foundations of the entire adult foster care program. Recruitment of good sponsors is, of course, essential; however, in the long range operation of a good adult foster care program, thought and planning should certainly be given, also, to recruitment of guests. This latter form of recruitment might be seen by some agencies as a passive thing; namely a process limited to accepting referrals from various agencies - non-recruitment, if you will. It can also be viewed in a more aggressive vein as an active case-finding situation. Since there is a real need for this program, I feel that guest recruitment should not be excluded because of its genuine service to the community.

Marathon County has two levels of sponsor recruitment. Foremost and ongoing is the simple classified ad under "Help Wanted" in the one local daily newspaper which has county-wide circulation. This is the source where the agency picks up the great bulk of all potential sponsors. Classified ads are direct, to the point, and bring in the sponsor who is ready and able to enlist in the program right now. The agency has an annual contract with the daily newspaper in Marathon County, and this space is usually divided over the weeks and months

between our child foster care unit and the adult foster care needs. The ad in the classified section, even if it is only a few lines, draws better than any type of display advertisement. As anyone who has done consistent advertising knows, it is the repetition that counts. After advertising for a couple of years in this consistent manner, the agency getting people who open the intake telephone conversation with such comments as: "I've been seeing your ad for adult foster care sponsors for so long that I'm beginning to feel this ad is directed personally at me. I just couldn't help answering the ad and letting you know that I want to be considered as a sponsor." Sometimes the prospective sponsor also states that he has felt inadequate or embarrassed to apply when the ad first appeared, but the constant reading of the ad week in and week out finally had given him enough courage to respond or, perhaps, the specialized request for a specific type of sponsor seemed to speak directly to him. At any rate, the newspaper has almost total coverage of the hundred thousand plus population of Marathon County with the result that our five or six line ads draw from one to ten answers per week, depending on the season of the year. Summertime is the slowest recruitment season and, therefore, requires more advertising to get the same results. Good sponsor recruitment which leads to final certification is about at the ratio of 1-3 from current responses to these classified ads. The remaining 2 of 3 initial contacts from the classified ads go on our *Friends of the Program* list and may be referred to at a later time. Sometimes the timing is bad or there are other factors that make immediate certification impossible; but we do not throw these names out but may refer to them at a later time.

The second line of sponsor recruitment includes the speaking engagements to service clubs, such as luncheon groups and church organizations. The agency circulates all of the churches in Marathon County semi-annually with brochure material inviting them to call on us for speaking engagements. These speaking engagements rarely result in a direct request for sponsorship; however, they are essential in keeping the needs of the program before the mind of the community. The same applies to television and radio appearances as a means of broadcasting the adult foster care program.

Word of mouth recruitment of sponsors should also not be overlooked. Often one good sponsor will recruit another. This is the best kind of reference any program can have and does occasionally occur. Our local Sheriff's

Department has, from time to time, referred people in the rural areas for sponsorship because they themselves have seen some of the good effects of our program, and this despite the fact that they have sometimes been involved in some of our crisis situations, such as bringing a guest in from the outer reaches of the county to the Health Care Center on an emergency re-admission. So when the Sheriff's Department thinks we have a good program and recommends it to some new person we feel this to be a genuine compliment. Milk haulers, feed and seed salesmen who have seen our program in operation on some of our rural settings also pass the word of our program on to others who then call up wanting more information on our program.

Over against sponsor recruitments, which is pretty much matter-of-fact advertising, the recruitment of guests covers a much larger area and lends itself to genuine creative endeavor. For example, a recent Associated Press release (Wausau Daily Herald, August 25, 1976) speaks of the need of skilled nursing home beds in the southeastern counties of Wisconsin. It appears that hospital beds are being needlessly filled by patients who could be in skilled nursing homes, but that these skilled nursing home beds are filled with patients who likewise could do with lesser degrees of skilled care. One of the alternatives of these latter patients certainly could be adult foster care homes. How to get this message to the proper people is a case of skillful recruitment or case finding. Furthermore, getting doctors to think adult foster care instead of automatically referring their patients to nursing homes is also a part of creative recruitment. Finally, getting the entire citizenry to know what adult foster care consists of can also fall under the heading of guest recruitment. All these areas are real challenges.

The adult foster census in Marathon County has been holding steady around the 90 mark for the last six months or so. These 90 guests are living in about 50 different adult foster homes scattered around Marathon County. About 50 percent are placed in rural homes, with the other 50 percent in homes that might be classified as metropolitan. Placement usually rotates around the question of the treatment program for the individual guest. The younger guests, those in their 20's and 30's, are usually placed in the metropolitan area because of the closer proximity to metropolitan services such as workshops, education achievement centers, technical institutes and medical facilities. Those who are not actively involved in some type of training can more easily be located in rural

settings.

All placements are, of course, voluntary. Each guest is given two or three placement visits to different homes that he himself has selected in terms of location, family size, proximity to relatives, site and location of bedrooms, and the like. Similarly, the sponsors have total freedom as to what guests they would like to have living with them. Freedom of choice is the name of the game; nobody twists anyone's arm. To develop confidence in the sponsors, the agency keeps repeating that there are no failures in our program. If a guest should last only a week in one placement, he might only have lasted a day in another. The agency tries to keep options open for guest and sponsor alike at all times.

A few thoughts may be inserted at this point on the issue of a single home or family for both child and adult placements. Marathon County has a few such homes that are certified for both adult foster care and licensed for child foster care. This can occur either because the staff feels that the home is an especially versatile home, or, since there are no current placements of one category in the home, it can then well be used by the other unit. This situation also arises when a child who is nearing 18 needs to be placed, and the feeling is that the relationships that may be built up had best not be terminated at age 18 just because the home is not licensed for adult foster care. We have, therefore, had homes in which, perhaps a 17 year old and a 19 year old boy might be in the same home under different certifications. There are, of course, potential pitfalls in this dual licensing that would occur to any practitioner, such as placing a teenage girl in a home with a young man in his 20's. Also, placing a bright youngster in a home in which there are retarded adults would have to be conscientiously weighed. It is apparent that especially fine screening is necessary in placing both children and adults in one home.

Inservice Training for Sponsors

Marathon County has a loose association of sponsors that serves two purposes: in the first instance, an opportunity for training and educating; and secondly, fellowship and getting to know other sponsors. For the past two years the association has tried to meet about four or five times during the fall and winter months in an evening meeting in which some professional, psychiatrist, doctor, nurse, or agency staff person, would give a brief presentation on some topic of mutual interest.

Presentations are followed by small group meetings to discuss the concepts presented; to get acquainted; and, to share mutual concerns. Occasionally, the association meets at the agency; other times it meets at the County's mental health facilities, or the Community Living Center, a new facility designated as an adult day treatment program that is a community alternative to in-patient treatment. The association also has available to it the resources of the local vocational-technical institute, that stands ready to deliver tailor-made courses for adult sponsors. In-service training for adult sponsors might not be as urgent or necessary as for child foster parents for two reasons. One, is the fact that our sponsors are usually older, more experienced people who have met many of life's vicissitudes and have consequently developed their own coping mechanisms; and, secondly, the guest also has experienced quite a bit of life, is more case-hardened in his habits and might be less responsive to strategies of change. At present, the agency is trying to develop a series of five or six teaching sessions that might serve as a general introductory course for all new sponsors - to be repeated from time to time as needed.

In planning any training sessions for sponsors, especially rural sponsors, it must be kept in mind that evening meetings are difficult to arrange. Rural people who live on the farm have chores, and it is harder for them to get away for a meeting beginning at 8:00 than for city folks who normally quit their job at 5:00. Program developers should not feel slighted if the sponsor gives priority to his cows rather than to a training session. Driving 50 miles over ice-covered roads can also be a deterrent not to be dismissed lightly. In other words, rural people coming out for an evening meeting often should be given two gold stars for effort!

The Care Team

One of the genuine keys to success in Marathon County's adult foster care program certainly lies in the adult foster care treatment team, which comprises not only social workers, and social service aides, but also medical personnel, visiting nurses, volunteers, and occasionally, homemakers. The County Department of Social Services has a working arrangement with the county and city nursing departments by which they are automatically alerted to adult foster care placements, and they respond by visiting the guests in the home a minimum of twice annually, and more if necessary. The nurses are particularly capable

of spotting problems with medication and can also gain entry into a doctor's office on short notice. They are available on 24 hours call, seven days a week. This kind of close contact with the nursing profession is felt as a real support to the sponsors. Volunteers are used mainly where continuous medical transportation is needed or as the occasional friendly visitor. The agency does not use its county social service homemakers to assist the sponsors while the guest is in the home because it feels that the sponsors themselves are adequate or superior homemakers; but homemakers are called on as team members when guests are planning their moves to independent living. Here homemaker services are of genuine assistance. In Marathon County the team consists of one full-time coordinator who recruits, certifies and reviews the homes and also coordinates placements; two social workers who share the 90-odd guest case load; and one part-time social service aide who helps primarily with pre-placement and placement visits and does some of the statistical reporting. The sponsors hear this repeated refrain: "We're a team; we don't drop off a guest and let you sink or swim. We're as close as your telephone and we're here to help." The agency sincerely does its best to perform on this promise.

Since approximately 60 percent of the program's referrals come from the local (Mental) Health Care Center, there is a weekly joint staffing with the social workers and case managers at the Health Care Center. In attendance at this meeting for the Department of Social Services are the two social workers who share the guest case load; the social service aide whose principal job is attending to the pre-placements and placement visits; and the adult foster care coordinator. These two-hour sessions, usually cover new referrals and sharing of significant contacts that were had with any guest or sponsors over the past week. Statistics and long-range planning between our two agencies are also shared.

These staffings with the Health Care Center also give us a weekly chance to go over the selection of guest placements. Not only is special attention given to the physical; mental and emotional equipment of a potential guest, but care is used to match a guest with the expectations and capabilities of potential sponsors. Matching and selection is an element in the mutual staffings that receives a lot of time and thought.

It is felt that this weekly staffing with one of the major referral sources of the program has helped to make the program operate as smoothly as

it has over the past two and a half years. It is quite indispensable.

Conclusions

Adult foster care is a needed program. Adult foster care is not a difficult program to implement. It does not require large blocks of staff. It is well received by the public, and also saves taxpayer dollars. While it can be implemented in both urban and rural areas, Marathon County Department of Social Services feels that rural areas have an edge in recruitment of sponsors. The rural environment gives more opportunity for avocational projects, and rural families are often not as nuclear as urban families. Also, rural homes are usually larger and have spare bedrooms. These two factors make taking in that "extra person" more natural and easier.

THE ROLE OF THE NURSING HOME OMBUDSMAN PROGRAM IN RURAL WISCONSIN

Judy Zitske

A Brief History

An investigation of the nursing home industry conducted by the office of Lieutenant Governor Martin Schreiber in 1971, uncovered serious deficiencies in the procedures for licensing, inspecting, and regulating nursing homes in Wisconsin. Procedures for the enforcement of state and federal regulations were found to be clearly ineffective. Concerned about the problems uncovered in the study, the Lieutenant Governor of Wisconsin applied to the U.S. Department of Health, Education and Welfare for a contract to operate a demonstration Nursing Home Ombudsman Program in Wisconsin. The contract was approved and awarded as of July 1, 1971. At the same time, demonstration projects were funded in Michigan, South Carolina, Pennsylvania, and Idaho. Oregon and Massachusetts were added the following year, and the seven demonstrations continued with federal funds until July of 1975. The Wisconsin project was then fully funded by the state, and several of the other programs have continued as well.

What Does the Ombudsman Do?

In the first three and a half years of its operation, the Wisconsin program, with offices in Madison and Milwaukee, was unable to adequately determine and deal with problems in the primarily rural and northern third of the state (or the upper 19 counties). A small grant was obtained from the federal government, and in January, 1976, a northern office was opened in Rhinelander with a staff of two to cover the 19 counties. The Wisconsin Nursing Home Ombudsman Program has two major tasks: (a) to establish effective and viable means for receipt and resolution of nursing-home related complaints, and (b) to document significant problems in the system of long term care and, in turn, stimulate improvement of the Wisconsin system. The northern office has agreed to attempt to accomplish a third task as well, to meet the unique needs in this primarily rural area: (c) to develop the ombudsman program at the community level; the staff members, called Ombudsman Developmental Specialists, are to provide

leadership in inaugurating in as many areas as possible, community action programs to identify and deal with nursing home complaints and to provide help to residents, homes, and communities in improving the quality of care.

What Is An Ombudsman?

The classical concept of an Ombudsman is an independent and impartial governmental officer who receives and investigates complaints from the public against administrative actions and agencies in an objective manner. Simply stated, the ombudsman should be a liaison between citizen and his government and may investigate complaints of bureaucratic abuse. Although the term is not synonymous with advocate, nursing home residents are so vulnerable to violations of their rights that they especially need advocacy around their rights to allow them to maintain their dignity and self-respect. They are extremely vulnerable to mainpulation and exploitation by the very persons upon whom they are forced to depend.

Complaints

In the first three months after the northern office was opened, the two staff members visited all of the 73 homes in the 19 counties. This stimulated a number of complaints and contacts and gave the ombudsman a basis for comparison among the homes and the resources (or lack of them) in the various areas. An immediate difference between urban and rural areas became apparent: there is a general willingness to admit to problems in nursing homes in urban areas and primarily in cities; most of the widely publicized scandals and horror stories have centered in the large nursing homes of cities such as Milwaukee, Chicago, and New York. By contrast, people in rural areas often seem to be unaware of serious problems in the homes in their small local communities, even when these problems are readily apparent to the ombudsmen visitors from outside of these areas. This may be because the ombudsmen are objective and have a wide basis for comparison. In any case, it has been established that many serious problems do exist in small nurs ng homes in rural areas; in fact, the Ombudsman Program is able to demonstrate, at least on the basis of six months worth of statistics, that the problems themselves are very similar to those found in urban based nursing homes.

Through comparisons of complaints, using the statistics compiled in the

space below, one can demonstrate how, although the complaints are similar, the methods of resolution are quite different in the urban and rural settings.

NURSING HOME OMBUDSMAN PROGRAM STATISTICS Compiled July 26, 1976

CLASSIFICATION	MADISON-MILWAUKEE (Urban Setting)		RHINELANDER (Rural Setting)	
I. CARE/QUALITY	NO.	PERCENT	NO.	PERCENT
1. Neglect	{477}	{21}	12	10.5
2. Abuse			1	1
3. Rights/dignity	165	7	9	7
4. Lack of Professional Services	293	13	15	13
5. Lack of Activities	41	2	8	6.5
6. Dietary problems	264	11	18	14
TOTAL	*1240*	*54*	*63*	*52*
II. FINANCIAL/LEGAL				
1. Items lost or stolen	70	3	3	2
2. Lack of money/benefits			8	6.5
3. PLA/extra charges	{284}	{12}	5	4
TOTAL	*354*	*15*	*16*	*12.5*
III. ADMINISTRATIVE				
1. Poor administration	312	13	9	7
2. Inadequate staff	(Covered under I.4)		3	2
3. Inadequate training	(Covered under I.1-2)		1	1
4. Bedhold problems	N/A		2	1.5
5. Resident transfer	N/A		7	6
TOTAL	*312*	*13*	*22*	*17.5*
IV. PHYSICAL PLANT PROBLEMS				
1. Building	{145}	{6}	7	6
2. Housekeeping			4	3
TOTAL	*145*	*6*	*11*	*9*

CLASSIFICATION	MADISON-MILWAUKEE (Urban Setting)		RHINELANDER (Rural Setting)	
V. NON-FACILITY RELATED	NO.	PERCENT	NO.	PERCENT
1. Inappropriate or illegal practices involving care	N/A		3	2
2. Regulatory Agency problems	N/A		4	3
3. Lack of Service by outside providers	60	3	4	3
4. Pharmacy problems	212	9	1	1
TOTAL	*272*	*12*	*12*	*9*

COMPLAINT CLASSIFICATION SUMMARY

CLASSIFICATION	MADISON-MILWAUKEE		RHINELANDER	
	NO.	PERCENT	NO.	PERCENT
I. CARE/QUALITY	1240	54	63	52
II. FINANCIAL/LEGAL	354	15	16	12.5
III. ADMINISTRATIVE	312	12	22	17.5
IV. PHYSICAL PLANT	145	6	11	9
V. NON-FACILITY	272	12	12	9

COMPLAINT SOURCES

SOURCE	MADISON-MILWAUKEE	RHINELANDER	
	PERCENT	NO.	PERCENT
1. Relatives	49	16	23
2. Nursing Home Staff	{14}	4	6
3. Administrators		7	11
4. Residents	11	19	30
5. Friends	7	12	17
6. Others	12	--	--
7. Anonymous	4	--	--
8. Service Agencies	2	{8}	{13}
9. Regulatory Agencies	4		

Since the Ombudsman Program receives 20 types of complaints, it is easier to understand and to compare them if they are grouped. All the types having to do with care and the quality of life can readily be separated from those having to do with money, housekeeping, etc. It is immediately apparent that most of the problems about which the Ombudsman Program is notified are in this first category of care and the quality of life, and this is true for both numbers of complaints received for northern Wisconsin as well as central and southern.

Significant Problems in the System of Long Term Care

In addition to responding to complaints on an individual basis, the Ombudsman Program makes recommendations to the Legislature, the funding sources, and the regulatory agencies. The Program also makes public general problems about which it has become aware, so that the population as a whole may be informed From numerous visits to nursing homes and complaint investigations, each Ombudsman staff member has a perspective which identifies patterns of repeated and similar occurrences of mal-administration (whether in particular homes or in government agencies), and the recommendations go beyond the problems of any one complaint.

The Ombudsman Program's role has had a measurable impact on some of the problem areas around which projects have been developed. Some of the more recent statewide projects have been:

1. The problems cased for many residents on Medical Assistance when the personal living allowance was dropped from $45.00 to $25.00 in Wisconsin. The Ombudsman Program helped to bring about a compromise to $35.00 per month.
2. The casebook: a research writer worked in the Madison Office to develop a casebook including the compilation of complaint techniques and experiences from all seven of the demonstration Ombudsman projects which became available in January of 1975. It is called *Ombudsman for Nursing Homes: Structure and Process.*
3. The lack of alternatives to nursing homes and services to maintain people in their own homes:
   A major project resulting from the efforts of the Wisconsin Nursing Home Ombudsman Program is the development of the Community Care Organization, funded by the Kellogg Foundation and

the Department of Health, Education and Welfare. This project is attempting to demonstrate that locally based supportive services can maintain the elderly and disabled outside the institutional setting with a coordinated administrative structure and realistic private and Medical Assistance funding.

Wisconsin received the final go-ahead early in December, 1974, for the pilot project. About $6 million in Medicaid funds will be available for the services (including non-medical) provided during the test project. In addition, the Kellogg Foundation of Battle Creek, Michigan was awarded $33,000 over the three-year period for administrative and evaluation expenses.

La Crosse was selected as the first project site in July, 1975, and the project began services on January 1, 1976. A second test location in Milwaukee will be developed this year. If results are successful, an additional test site in rural northern Wisconsin will be set up next year. While the Community Care Organization project was designed specifically for the State of Wisconsin, it will have many implications for application on a national basis in both urban and rural areas.

4. The lack of incentive to nursing homes to provide rehabilitation in the present Medicaid reimbursement system:
Medicaid-covered services are traditionally limited to medically oriented services throughout the nation. Federal emphasis and payment is made for care after illness and disability have already occurred. Payment for preventative medical and social services is quite limited. Because of this emphasis, residents who are still active, but who require considerable amounts of rehabilitative or maintenance care, receive considerably less in Medicaid payment than they require to meet their needs.

Having received many complaints from nursing home administrators and other professional representatives regarding the system of evaluating patients, the Ombudsman Program sought a workable means of revising the system to emcompass the concerns regarding the psycho-social needs and incentives for rehabilitation/restorative services. The ultimate goal included a revision in the nursing

home reimbursement formula.

The Patient Evaluation Review Committee, a research project funded by the Wisconsin Regional Medical Program and designed by the Nursing Home Ombudsman Program, came into existence partially in response to the problems state above. The Patient Evaluation Review Committee is currently engaged in testing a Patient-Needs Assessment and Evaluation instrument which will provide meaningful information with respect to patient service needs (both medical and non-medical) and potentials for rehabilitation. This research project is gathering data on services rendered to the patient by type of personnel, and the amount of time taken to perform the service, so that an appropriate cost-related reimbursement system of Medicaid payments may be devised. It will help to insure that residents' non-medical needs will be more adequately met.

5. Legislation: the Ombudsman has successfully introduced or worked on several proposals for legislation which have been passed into law. These include: revising the definition of nursing homes to include county homes and county mental institutions, which operated under weaker regulations than nursing homes although they served a similar population; stipulating that nursing homes be surveyed within 120 days of issuing a new license, so that an attempt would be made to base licenses on current compliance; and the recently passed patients' rights legislation which added to the federal regulations and required that basic rights be insured for all nursing home residents rather than just those receiving federal funds.

The Wisconsin Nursing Home Ombudsman Program is working on some additional projects at this time, and these are some of the things it is hoped will be accomplished in the future:

1. A package of enforcement legislation: this was introduced into the special legislative session this summer, it will be reintroduced and passed in the 1976-77 session. It attempts to deal with the continued existence and prosperity of nursing homes which are in a chronic state of noncompliance with state and

federal regluations and create a bad name for all nursing homes. The bill will give the Division of Health more timely and effective procedures to use in enforcing the regulations.

2. Consumer education: The Ombudsman Program has completed a handbook on choosing and evaluating nursing homes, which will be available soon. This is to be used not only as an aide in choosing a particular home for someone to live in but in evaluating any nursing home with which an individual comes in contact as a visitor, volunteer, or whatever. This will be a tool to use to inform the public about the concerns of the residents of nursing homes and to enable them to help in relieving the problems and improving the conditions. This may be especially useful in rural areas where there are fewer professionals available to regularly monitor and evaluate the quality of care.
3. Actions to further the goal of putting the Nursing Home Ombudsman Program out of business: The long range result of improving the regulations, improving the system of enforcing the regulations, raising the consciousness level of the people as to the problems, and improving the ability of people to solve some of the problems themselves will all help to make the existence of an Ombudsman Program unnecessary. People in the industry can help to speed up that process, and the system of peer review proposed by the profit nursing home association in Wisconsin is a positive step. The proposed guidelines would enable some administrators to visit a large number of other nursing homes at length which we have found so valuable in developing a perspective on nursing homes in general. It would appear, however, that the areas to be evaluated on the proposed checklist rely too heavily on the documentation which is already routinely checked by the Division of Health surveyors. While good documentation is important, and essential to having good surveys, it does not guarantee contented, optimistic, and well cared for residents.

The Ombudsman Process in Rural Wisconsin

Specific nursing home complaints, assuming that these are not caused by intentional abuse, can usually be resolved by persuading all of the involved

people, such as the resident, possible relatives or friends, and the nursing home administrator, director of nursing, dietition, social worker, therapist, or whatever staff members are involved, to meet together with the ombudsman as mediator and work through the difficulties. Many of the factors which cause residents anguish and despair, however, unfortunately cannot be resolved in such a straightforward way. These are people who have lost, to a greater or lesser extent, their employment, income, health, friends, spouse, and most of their many years worth of accumulated possessions. In all too many cases, they have also lost their most basic rights to privacy, to freedom of movement, and to the control over their lives.

All nursing home residents have particular problems of accessibility, and these are compounded by whatever infirmities have caused them to be placed in nursing homes in the first place. The outstanding obstruction to accessibility however, can be identified as isolation, and this is a more serious problem in rural than in urban settings. The nursing home population is too frequently an ostracized society with little or no meaningful contact with the greater community. For this reason, it is extremely important to periodically visit all of the nursing homes to alert residents to the existence of an ombudsman program and its function; the use of a cadre of volunteer ombudsmen could be effectively used here as an outreach mechanism and as a liaison between these isolated people and their surrounding communities. It is one of the primary ombudsman goals to work with the people in these rural communities to arouse their awareness and concern about the problems of nursing home residents. What they so often need is continued contact, rather than occasional visits by ombudsmen or other professionals who come from far away, to keep from feeling isolated and abandoned.

People in rural areas generally have little access to services which are beginning to be available in rural areas, and this is probably more true for the elderly than the rest of the population. As the average life expectancy continues to increase, so will the problems of the rural elderly, and, statistically, older people are more likely to live either in the central cities of large metropolitan areas or outside these areas altogether than the population as a whole.[1] A particularly, at least potentially, vulnerable group of people is made up of elderly people who live alone. Among non-institutionalized elderly men, 17 percent lived alone in 1974; due to the longer life expectancy of women, more than one third, or 4.5 million, of them lived alone. If past trends continue, the Bureau of the Census estimates that the number of elderly

women who live alone will grow by over two thirds by 1990.[2] The potential problems for the large number of women who will live alone in a rural environment are obvious.

The implication of the previous statistics for nursing home residents is that because adequate home health services and low cost apartment housing are even now non-existent or inadequate to meet the needs of the rural elderly, there is at least the possibility that the numbers of people will increase faster than the services become available or that many of the services will continue to be inaccessible to the rural elderly. In that case, large numbers of rural elderly people will continue to be prematurely and inappropriately placed in nursing homes. Although nursing homes operate around a medical model, the people who are placed because of a lack of alternatives have especially pressing social and emotional problems, and, if the population trend predictions are accurate, these problems will be increasingly pressing in rural areas.

As was explained earlier, an ombudsman is not only an advocate for the nursing home resident; it is frequently appropriate to work on behalf of a home in resolving a problem, and rural nursing homes have unique kinds of problems. The rules and regulations, for instance, are generally directed to the larger homes and are urban oriented; many of the small rural homes are unable to comply and are going out of business.

Another problem, the lack of services and professionals in rural areas, is one which affects nursing homes as well as consumers. It is extremely difficult for many rural homes to obtain trained staff or to find resources to use in training the untrained. As the nursing home field changes, the need for continuing education increases, but few opportunities for in-service training are available in rural areas. As the only care providers for miles around, the rural homes contain an extreme range of disabilities among the residents. In addition to the wide range of health problems among the elderly, it is common to find them mixed with people of all ages who are blind, mentally retarded, alcohol or drug abusers, mentally ill, victims of cerebral palsy, and physically handicapped from car, athletic or other accidents; these factors increase the need for well trained staffs and additional trained professionals for consultation. As the ombudsman staff become aware of the resources which are available, it is attempting to act as a link to these resources and is, in addition, trying to stimulate their creation where none are available.

The problem of lack of choice exists for homes in having few excellent applicants among which to choose, for employees who have a limited number of job possibilities, and for consumers as well. All sides often must take what they can get, and this has an effect on the complaint resolution process in rural areas. There are whole counties with only one home, and it is common to find neighboring nursing homes as much as 50 miles apart in northern Wisconsin. When large areas are dependent on a single or a very few nursing homes to care for their elderly and disabled and to provide jobs for their communities, the people are not able to be very objective about the homes; they may have no basis for comparison and they may be resigned to what is available. The ombudsmen gain a great deal of information from people in the local communities and work with them to have frequent contact with the homes, but the objectivity that a professional from outside the area can provide is frequently invaluable in resolving problems.

Summary

In conclusion, the problems which the Ombudsman Program is encountering in rural Wisconsin may or may not be unique as compared to those of the other providers of services in rural areas. Although the northern Wisconsin office presently has the capacity, with two staff members to deal with the 73 homes in 19 counties, to directly and personally respond to all of the complaints which are received, intervention by the ombudsman is not always what is required to improve a situation. Ombudsmen alone can do little in continuing ways to relieve the isolation and painful loneliness which so many rural and institutionalized elderly experience. There is little ombudsmen can do alone to relieve the widespread despair of people who would not have to be institutionalized if adequate housing and services were more available in rural areas; these people are unhappy even in well-run, concerned nursing homes. Problems such as these require the involvement of the government, the providers of services, and the people in the communities at the local level before improvement can take place.

FOOTNOTES

[1]Blanch Williams, *Aging*, November-December, Office of Human Development, Administration on Aging, U.S. Department of Health, Education and Welfare.

[2]Ibid.

4 RURAL HEALTH CARE

Rural America is the geographic area most seriously effected by the maldistribution of physicians in the United States. While a number of prominent efforts are being made to recruit more primary care physicians for practice in small communities, there continues to be a pressing need for *physician extenders* not only in the form of allied health and social service professionals, but also in the form of preventive consumer health education. The papers in this section discuss such rural health issues as the overlapping medical-social problem of alcoholism, consumer training in prenatal care, and the need for more involvement of social work professionals in primary health care settings.

A CASE STUDY OF AN INNOVATIVE FIELD PLACEMENT IN ALCOHOLISM

Ruth Glosser

Alcohol has played an important role in the life of man since man first sipped the liquid collecting around honey or fruit left too long in a warm place. Early in history, wine became an integral part of religious ceremonies. The Bible acknowledge that "wine maketh glad the heart of man" (Psalms 104:15). In one beverage form or another, alcohol is known the world over and is more or less copiously consumed, even in those societies where its use is forbidden.

The use of alcohol is and always has been a matter of almost universal concern. Considerable research has been instituted to document incidence, frequency, and distribution of alcoholism in the United States. The role of alcohol in health and social problems in America is indicated by some of the basic facts about the number of drinkers and the quantities of alcoholic beverages they consume. In the United States alcoholism is currently the biggest health problem after heart disease and cancer. The facts are as depressing as they are impressive:

An alcoholic's life span is shortened by ten to twelve years.

In half of all murders in the United States, either the killer or his victim - or both - have been drinking.

A fourth of all suicides are found to have significant amounts of alcohol in their blood stream.

People who abuse alcohol are seven times more likely to be separated or divorced than the general population.

The dollar cost of alcoholism may be as much as $15 billion a year, much of it from lost work time in business, industry, and government.

At least half of each year's 55,500 automobile deaths and half of the one million major injuries suffered in auto accidents can be traced directly to a driver or pedestrian "under the influence."[1]

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has done considerable research which indicates that the largest proportion of heavy drinkers live in cities, while small towns and rural communities have smaller proportions of heavier drinkers.[2] Alcoholism, nevertheless, is a major problem

in rural areas, and resources available to help the problem drinker are often lacking or fragmented.

This paper will describe the development of a social work program which is training alcoholism specialists at the baccalaureate level and which utilizes the *Bedford-Somerset (Pennsylvanian) Drug and Alcohol Program* as a senior field instruction placement for students enrolled in the training program. Additionally, it will give a preliminary analysis of some of the needs, problems, and characteristics of a rural area in terms of designing a workable model for the delivery of alcoholism training and treatment services and explicate some of the innovative aspects in both the *Saint Francis College Alcoholism Training Program* and the Bedford-Somerset Drug and Alcohol Treatment Program.

Problems Related to Alcoholism Program in Rural Areas

Programs committed to delivering drug and alcoholism services to rural communities have had to contend with special problems. Central among such problems are: funding practices, including state funding formulas which give preference to metropolitan areas; cash local-match requirements; high costs for mileage and communication; lack of availability of trained staff; and little or no communication on successful addiction treatment modalities used in other rural areas. Accessibility and availability of services with in rural areas are difficult to achieve in a large geographic area with a scattered population. These problems are made even more difficult with inadequate funding and unavailable rural service delivery designs.[3]

The Bedford-Somerset Alcoholism Program

In rural southwestern Pennsylvania, the Bedford-Somerset Drug and Alcohol Council has developed a two-county innovative, comprehensive program to provide a complete gamut of services for the addicted individual in a non-drug, non-hospital setting.

The program, begun five years ago under the leadership of Carl Amenhouser, Drug and Alcohol Program Director, and with the support of the eleven member Bedford-Somerset Drug and Alcohol Council has grown from a one room counseling center with a "hot-line" to a complex of education, habilitation, and rehabilitation community-oriented services which employs a staff of twenty and is open

round the clock, seven days a week.

The program, headquartered in a former motel-bar complex in a strip near the Somerset entrance to the Pennsylvania Turnpike, offers primary, secondary, and tertiary prevention services.

The Detoxification Program

In terms of tertiary prevention, the program offers the addicted individual detoxification services in the Detoxification Unit of the complex, where a direct but non-confrontive therapeutic approach is utilized through supportive counseling and investigation of alternatives.

Eight staff members are assigned to the Detoxification Unit, and there are several of them on the unit around the clock. Over half the staff in the unit are recovered alcoholics, and a good many of the staff are local people. Most of the staff in this unit have received on-the-job training, and all of them are trained and experienced in treating toxicity and withdrawal symptoms. In addition, a full-time registered nurse is on the staff, and an area doctor is on call and available when needed. The physician visits the unit on a regular basis every day or every other day.

The program de-emphasizes the use of medication. The non-hospital atmosphere of the unit is further emphasized by the fact that both the physician and the full-time nurse wear street clothes rather than uniforms.

In lieu of medication, program personnel employ biofeedback techniques with all clients in the detoxification unit with the goals being anxiety and tension reduction plus self-image changes. Through the use of electromyograph muscular training, electroencephalogram-alpha theta training, temperature control training, and galvanic skin response biofeedback training, clients have been able to develop an internal coping method for dealing with uncomfortable thoughts and feelings without the use of mind altering drugs.

In addition to physical detoxification, the objectives for the individual in this first week of treatment are: establishment of an orderly routine, education on alcoholism and addiction, familiarization with group processes, and the recording of significant observations and suggestions for the later therapeutic follow-up in the client's individual file.

The Residential Treatment Program

Between fifty and sixty percent of the clients go from the Detoxification Unit into the Residential Treatment Program. Treatment here ranges from a thirty day minimum to a maximum of ninety days, although some clients have remained for periods up to a year. Entering clients are assigned to a counselor, and arrangements are made for individual counseling. The staff in the Residential Treatment Program consists of five counselors and a psychologist. The background of the counselors is varied, including among others, a former salesman, a registered nurse, and a teacher. Again, as is the case with staff in the Detoxification Unit, half of the staff are recovered alcoholics.

Through individual sessions with their counselors and through regular group meetings with the therapeutic community and with Alcoholics Anonymous, individuals in the Residential Treatment Program have an opportunity to deal with their addiction and to find ways to live free of any mood altering substances.

Outpatient Services

Upon successful completion of the Residential Treatment Program, individuals move into out-patient therapy and counseling. Groups meet at the Center six days weekly and individual counseling is available at Help Centers throughout both counties. The Drug and Alcohol Program also attempts to involve the client's family through family therapy and spouses groups.

Trends

In the five years of the program's existence certain trends and changes have become apparent. In terms of the average age at entrance, for example, program statistics show a sharp downward trend from age 55 to 30. The youngest person admitted into the detoxification program was 14, the oldest, 75.

Women constitute twenty percent of those admitted, and a women's group has been instituted on Wednesday afternoons. Exploring and learning about sensitive, personal feelings is the focus of the women's group. The atmosphere is low-key, and a feeling of acceptance and understanding is a priority. The group is open to any woman who thinks she may have a problem with drugs and/or alcohol.

In terms of adolescents, the program finds that young people are indiscriminate in their use of drugs and that most of the teenagers admitted are cross-addicted or poly-drug users.

Preventive Programs

While much of the thrust of the program is devoted to treatment approaches for the addicted, a portion of the total program is aimed at the non-user of drugs and/or alcohol. The purpose of this part of the program is to better inform the public at large about the use and abuse of drugs and alcohol. This objective is carried out through a speakers' bureau, through films and literature, and through Community Help Centers located at strategic points throughout both counties. The Help Centers provide the region with a drop-in and telephone contact for drug and alcohol information. The centers are an informational, referral, and counseling service designed to assist people in gathering information and reaching the people or agencies which can help them. Additionally, the program sends out a monthly newsletter to all area agencies, physicians, school districts, attorneys, and anyone else who might be in contact with people who suffer from the problem of addiction. Circulation of the five-page newsletter is now approximately 500 copies.

In keeping with the rural concept of distrust of the outsider, it has been helpful in terms of community acceptance that local people have been employed and trained whenever possible. This is especially true in the Detoxification Unit.

Building Community Acceptance

Community acceptance of the program has been generally favorable. In essence, however, the community perceives the program as a "fire house" or the place to call upon when a building is on fire. In terms of alcoholism this has meant that the community has come to look upon the Bedford-Somerset Drug and Alcohol Program as a viable resource for the identified alcoholic who is in trouble or causing trouble but has little interest in or awareness of preventive measures in regards to alcoholism. In an effort to counteract this community impression of the program as an emergency resource, only several new programs are underway to offset this "emergency" bias.

One of the more innovative measures being instituted by the program is one reaching out to teachers and guidance counselors in the area school districts. In this primary prevention effort four teachers, one each from different school districts, will be selected each quarter year for twelve weeks of training. The "carrot" for their training is that they will be paid $6.00 per hour while they learn. The basic thrust in their education will be to train them to identify those children and/or their families in their school district having an alcohol or drug related problem, so that interventive strategies may be instituted before the problem gets out of hand. By the end of the school year, it is the program's goal to have sixteen teachers involved in the program, or one "agent" in each of the school districts in the two-county area.

Another innovative program being utilized by the Bedford-Somerset Council has been its outreach approach to area business and industry. Here the objective has been to use the place of work to identify and refer employees who are experiencing work difficulties because of addiction to alcohol or other drugs.

Each company in the two-county area is asked to designate one official, usually in personnel or industrial relations, to act as the Employee Assistance Representative (EAR) to work in concert with a union representative. The EAR refers that employee to the Bedford-Somerset Drug and Alcohol Center for them to identify the employee's problem, whether it be with alcohol, other drugs, or other personal problems. The Center then will evaluate and involve that employee with the appropriate resource in the community for help. In-depth training is offered to enable the EAR to fulfill this role effectively. Last spring, for example, the program in cooperation with the Bedford and Somerset Chapter Jaycees, offered a free two day Labor-Management Alcoholism Seminar, which was funded by an "Operation Threshold" Jaycee Grant and local Drug and Alcohol Program monies.

Work With Other Community Agencies

Another innovative treatment approach being used by the Bedford-Somerset Program is their arrangement with the Somerset State Hospital for the mentally ill and with the Bedford-Somerset Mental Health/Mental Retardation Program, which permits institutionalized patients with alcohol-related problems to spend five days weekly in treatment at the Center, returning to the State Hospital every evening. Center workers also work with the staff at the State Hospital,

going to ward conferences, etc. This practice permits and encourages cross-pollenization of ideas and concepts about alcohol abuse and treatment modalities.

The Saint Francis College Social Work Training Program

The Bedford-Somerset Alcohol Program is utilized as a field instruction placement for social work students at Saint Francis College. The Social Work Training Program, to our knowledge, is the only C.S.W.E. accredited undergraduate social work program in the United States to train alcoholism specialists on the baccalaureate level. It was developed in response to the need for professional workers in alcoholism treatment in the widely scattered rural communities of western Pennsylvania. Impetus for the initiation of the training program was also in part due to the fact that Cambria County, in which the College is located and which is adjacent to Bedford and Somerset counties, has the highest reported rate of alcoholism in a rural county in Pennsylvania. It is a county located in the southern Alleghenies region of Appalachia, a region below the national norms in income, education, health, and social services.

The training program encompasses a number of innovative features. A reciprocal teaching and student learning experience between Saint Francis College and Indiana University of Pennsylvania is being instituted, a four credit course in alcoholism has been added to the social work curriculum, and student field placements at many of the major alcohol rehabilitation facilities in the neighboring communities have been provided.

The NIAAA program-approved training program provides a course in alcoholism, which is taught by social work faculty member Claire Sackin, Ph.D. It is designed for college students who plan to be professionally active in the field of alcoholism treatment, as well as for those interested in expanding their knowledge in the social problem area. The content, reflecting a multi-disciplinary approach, includes a number of teaching modules which can be expanded to meet the needs of graduate students and alcoholism specialists who wish to extend their knowledge base. Emphasis in class discussions is on treatment approaches, government policy, and recent research findings, all of which reflect changing attitudes and the emerging importance of alcoholism as a national health problem. Students are required to supplement their classroom work with written reports of their observations of a self-help group and a rehabilitation facility in the community. Evidence of other relevant group

participatory experiences which will become the nucleus of a resource center on alcoholism is additionally mandatory.

Students in the program have a first semester senior year block field instruction placement under supervision in settings dealing with alcohol-related problems. In the final semester of the senior year, a senior seminar provides students with the opportunity to select and examine special aspects of alcoholism for further study and research.

It is during the first semester of the senior year that students have the opportunity for placement in an alcohol related program. In the current 1976-1977 academic year, three Saint Francis College social work majors are interning at the Bedford-Somerset Drug and Alcohol Program. The students are housed in the Residential Section of the program and are on duty four days weekly, Tuesday through Friday, from early September through December. They return to campus each Monday for a seminar to help them synthesize theory and practice experience. Because of their close proximity to the clients, the students develop a very special relationship with them. In the initial phase of their field placement, the students are given an overall exposure to all phases of the program. Depending upon their particular interests, they are then allowed to concentrate on particular aspects of the program. All of them receive training in the use of biofeedback techniques and treatment and prevention aspects of the program. Students receiving this kind of training develop valuable skills for future work with alcoholism and alcohol abuse.

Conclusion

There are a number of innovative aspects of alcoholism treatment and training being offered by the Social Work Program of Saint Francis College and the Bedford-Somerset Drug and Alcohol Program which demonstrate that it is possible to develop a meaningful, innovative spectrum of services for the alcoholic in a non-metropolitan area. Some of the innovative features mentioned have included a course on alcoholism featuring treatment procedures; the use of experiential learning in alcoholism rehabilitation field placements; the use of biofeedback techniques in detoxification procedures; and an outreach primary prevention program which pays community residents to learn.

Any service delivery program is shaped to a considerable extent by the needs, problems, and characteristics of the area and clientele it is designed

to serve. While the need for services to the alcoholic and his family in this southern Alleghenies region of Appalachia is well documented, delivery of these services has been complicated by lack of availability of trained staff, the large geographic area to be covered, the scattered population, and the conservative outlook of a non-metropolitan population, slow to accept new personnel and new programs.

Despite these obstacles, as mentioned above, the Bedford-Somerset Drug and Alcohol Council has initiated and developed an alcoholism treatment program which has achieved community acceptance and delivered needed services to a scattered population in creative, meaningful ways.

Saint Francis College, in response to the demonstrated needs for alcoholism training and concerns about alcohol abuse in the area, has developed an alcoholism training program which is training alcoholism treatment specialists.

The integration of the College alcoholism training program and the innovative Bedford-Somerset treatment program has resulted in the provision of a quality spectrum of services to the alcoholic and his family in this rural area of Pennsylvania.

FOOTNOTES

[1]"Alcoholism: New Victims, New Treatment," *Time*, (April 22, 1974), page 75.

[2]U.S. Department of Health, Education and Welfare, Public Health Service, Second Special Report to the U.S. congress on *Alcohol and Health, New Knowledge*, Preprint Edition, June 1974, from the Secretary of H.E.W., page 18.

[3]Bedford-Somerset Drug and Alcohol Council, *Dialogue*, Vol. 2, No. 12, August 1976.

AN APPROACH TO MATERNAL AND CHILD HEALTH SERVICES IN A RURAL SETTING

Marie Millington

Group prenatal education for prospective parents was initiated as a pilot project in Wisconsin Rapids, Wisconsin in 1970 and 1971. It was a cooperative effort including Wood County public health nurses, the county Extension home economist, local physicians, nutrition program assistants, hospital nurses, and University of Wisconsin Extension Community Health Staff.

Wisconsin Rapids, with a population of 18,587, is located in the southern part of Wood County. Wood County's total population is 65,362. It is largely a community of white middle class families. There are few specific poverty pockets, but lower socioeconomic families are scattered throughout the area. In 1970 there were 3,565 women between the ages of 15 and 44 years in Wisconsin Rapids. There was a total Indian population of 268 in 1970, 146 of whom were females. There were only 8 black people in the entire county. The United States Bureau of the Census reported the median income in 1970 to be $9,733 in Wood County, as compared with $10,068 for the state. Thirteen percent of the families had incomes under $4,000. The main economic enterprise in the county was the paper industry. Other main sources of income were cranberry production and dairy and beef farming.[1]

The project plan began with a contact by personnel from University of Wisconsin Extension, Community Health with the Wood County public health nurses and Extension home economist. It revealed a need for prenatal education in southern Wood County area, in and near Wisconsin Rapids. Local physicians and public health nurses had been individually attempting to provide the needed education, but both groups recognized that their efforts were inadequate, in that they were reaching only a small proportion of those who were in need of education. At that time another group, the nutrition program assistants, were also made aware of the need. Nutrition program assistants are women who have been trained through the federal Expanded Food and Nutrition Program, to assist low income homemakers to improve their home management skills. They are paid nonprofessional leaders recruited from the clientele to be served. As they visited homes to assist families, they were receiving questions about health

care during pregnancy which they were not prepared to answer.

The possibility of offering group instruction was considered. It would not only make it possible to reach a larger number of expectant parents, but would also provide the support that results from such a group learning process. Up to that time prenatal classes had never been held in Wood County. An inter-agency approach was explored. If such an effort were to be initiated in that area by combining the efforts of the agencies offering health services in the community, it could also serve to coordinate and strengthen their relationships with each other.

There was a period of waiting until the physicians were contacted, their approval received, and their participation obtained. A local advisory committee was then formed to determine community response to the idea and to gain their support and assistance. A professional steering committee consisting of county, district, and state representatives of public health nursing and home economics extension education was formed to aid in developing objectives and guidelines for the project.

All of those involved, participated in the recruitment, as well as in the class instruction. The usual content taught in prenatal classes was included, such as the importance of early and regular prenatal care; nutrition during pregnancy and lactation; anatomy and physiology of pregnancy, labor and childbirth; postpartum care; and care and feeding of the infant. The one aspect that was different in those classes was that a greater emphasis was placed on nutrition education than in most series of classes. Results of recent reports on nutrition during pregnancy made a particular emphasis on nutrition seem important.[2-3-4-5] A segment of each class was devoted to teaching nutrition.

It was decided to hold the classes at a hospital. The classes were designed for women who would be delivering there and it would enable them to become familiar with the setting. It would also facilitate the tour of the maternity unit and the involvement of the hospital nurses and the physicians. It had also been determined from a prenatal education project conducted by University of Wisconsin--Extension personnel in the Inner City-North of Milwaukee, that expectant mothers prefer to attend such classes in the hospital.[6]

Public health nurses gave the health instruction and the home economist, assisted by the nutrition program assistants, taught the nutrition segments.

The physicians discussed aspects of prenatal care that they thought were important and answered the questions of the class members, and the hospital nurses conducted a tour of the maternity unit and talked with the class about care during the hospital stay. Live babies were bathed in the class on baby care. A member of the local advisory committee brought her baby for the first series; in subsequent series class graduates brought their babies and bathed them. Literature was provided and films were shown relating to the subjects presented. The county public health nurses maintained a contact with the expectant mothers following the classes; through the remainder of the pregnancy, the delivery and the post partum period, including the baby after delivery. Reports were sent to the physicians at the end of each series informing them of which patients of theirs had enrolled, and which classes each had attended. Class members were asked to evaluate the classes at the end of each series, and an evaluation session was held at the end of each series, with all of those who had assisted with the series participating.

The classes were announced in the newspaper and on the radio, in addition to the individual recruitment. Three pilot series were held during the project with an attendance of 31 in the first series, 40 in the second series, and 21 in the third series, making a total of 92 who attended during the project. The classes were held in the afternoon so it was not convenient for most fathers to attend, but it was decided by the class members to hold selected classes in the evening so that fathers could attend. It was decided that the tour of the maternity unit and the class on the baby bath would be held in the evening. Sixty five percent of the expectant mothers who attended were in their first pregnancy. Their age ranged from 19 to 40 years. Three of the expectant mothers were over 35 years of age, placing them in a high risk category due to age. One of the expectant mothers attending was a young unwed girl having her first baby. The baby arrived before the series was completed. Both the nutrition program assistant, who had referred her, and public health nurse who would assist her at home, visited her in the hospital. She returned to the classes to complete the series after her delivery and brought another unwed pregnant girl with her.

It was an objective of the project to find expectant mothers who had not as yet seen a physician. All of those who attended the three series were already under medical care when they enrolled, however. This was not surprising when sources of referrals were examined, as it was learned that 71 percent of

all of the expectant mothers who had attended the classes had been referred there by their physician. Finding persons who are not under medical care and assisting them in seeking care seemed to be a valid goal to continue to strive for as classes continued in the future. Only 5 percent of those who attended the three project series were referred by the nutrition program assistants, but these were all women who fell in a high risk category, and were in particular need of the instruction.

It has been demonstrated that individuals from the target population, participating as members of the health care team are very helpful in reaching those individuals who particularly need to be reached, regardless of whether they are in urban or rural areas. The neighborhood aides or nutrition program assistants are often able to bridge a gap in communication between the professional and the person in the community, and they also can act as a patient advocate in the use of the health care system. Results of University of Wisconsin --Extension, Community Health projects have shown this approach to be equally effective, whether working with black families in Milwaukee's Inner City-North, or more recently with Spanish speaking families in Milwaukee's Inner City-South, or the nutrition program assistant working with the lower socioeconomic families in Wood County.

The classes have been continued at regular intervals since they were initiated during the project five years ago, and the enrollments have grown to double of that of the intitial classes. In addition, prenatal classes were started in Marshfield, in northern Wood County, following the success of the project. The enrollments were comparable to those of the Wisconsin Rapids classes at the outset and continued to increase at about the same rate.

It was recognized that the goals of reaching more expectant mothers with prenatal education and that of improving communication and coordination between the involved agencies were achieved. Coordination of services is always important, regardless of where the activities are taking place, but it does seem that shortages of personnel, gaps in services, and longer distances between family dwellings make coordination particularly important in the rural areas.

The report of this little project is a success story about the development of a method for providing a health service. However, it does seem that there are some factors other than attention to method and good organization of programs that are affecting the quality and the kind of programs that are being

offered in rural areas today. Rural health programs are being affected by the increased involvement of the federal government in the health care system. The number of programs has increased and new programs have moved into positions of high priority due to either federal recommendation or mandate. Support and assistance in strengthening services at the local level, where the action takes place, have not been provided proportionately be either the federal or the local government, however. As a result, preventive services are either given a lower priority in the program or services are weakened and are provided superficially, in an effort by the agencies to meet the demands that are made on them. It is my opinion that it is extremely difficult to provide quality health care in rural areas today as the situation exists. Ways need to be found to facilitate and extend the delivery of care. Assistance is needed from outside the agency, but certain adjustments can also be made from within. Group education can be one of these. It can result in reaching larger numbers of people without increasing the nursing time involved.

FOOTNOTES

[1]Ruth Conone, Jane Mensching and Marie Millington, *Prenatal Education-Interagency Cooperation,* Project Report, 1971.

[2]*Maternal Nutrition and the Course of Pregnancy-Summary Report,* Committee on Maternal Nutrition, Food and Nutrition Board, National Research Council, National Academy of Sciences, United States Department of Health, Education and Welfare, Washington, D.C., 1970.

[3]New American College of Obstetrics and Gynecology Statements, "Position Statement or Nutrition and Pregnancy," *ACOG Newsletter,* January 1973.

[4]Final Report by The White House Conference on Food, Nutrition and Health, Section # Establishing Guidelines for the Nutrition of Vulnerable Groups (With Special Reference to the Poor), Panel #1. *Pregnant and Nursing Women and Young Infants,* 1970, pages 37-45.

[5]H. N. Jackson, "Nutrition and Pregnancy, *Journal of American Dietetic Association,* 60 (1972): 26.

[6]Elizabeth Regan, Marie Millington and Mary Weaver, *Report of an Experimental Demonstration Project on Prenatal Education of Expectant Mothers Living in a Lower Socioeconomic Urban Area,* Community Health, Health Science Unit, University of Wisconsin--Extension, 1969.

THE ESTABLISHMENT OF SOCIAL WORKER PARTICIPATION IN RURAL PRIMARY HEALTH CARE[1]

Peter Hookey

Social workers can make valuable contributions to health care. That proposition is rarely disputed today, though agencies providing opportunities for such contributions are still scarce in some sectors of the health care field.

One such sector is the primary health care field. The literature contains descriptions of social workers' contributions in solo medical practices;[2] in fee-for-service group practice;[3] in pre-paid group practices;[4] in health maintenance organizations;[5] and in primary care residency clinics.[6] However, throughout the country as a whole the prevalence of such participation is minimal. Considering only agencies involving three or more physicians, a recent survey indicates that no more than three hundred agencies (3 percent of the total) have social worker participation.[7]

Most of these agencies are located in urban or suburban settings. At most a few dozen social workers are currently working in primary health care agencies in rural America.[8]

Clearly rural areas are very far from being saturated with primary health care social workers! However, this statement does not necessarily infer that an expansion of social worker involvement is to be expected. We must first ask whether more social workers want to practice in rural primary health care settings. No hard data are available on this issue. However, social worker unemployment is a nation-wide problem. There is currently a surge of interest in the profession in rural problems and life-styles.[9] In view of these predisposing factors, it seems reasonable to predict that at least a small supply of social worker manpower is available to flow into rural primary health care settings as program innovation opportunities arise.

Secondly, we must ask how such opportunities may arise. To provide a basis for a general discussion of this crucial issue, four cases of program establishment will be analyzed. Two of the programs have not yet been reported in the literature. They are described below. A comparative analysis section follows these program descriptions. This section encompasses discussion of two

further programs recently reported in the literature.

THE APPALACHIAN PROGRAM

Program Setting and Antecedents

Wilson Memorial Hospital Family Health Center is a teaching family medical practice center in Johnson City, close to Binghamton, New York. In 1972 an analysis of its patient population revealed that many patients were traveling considerable distances from outlying towns in the surrounding mountainous region. The administrators of the center were interested in improving service accessibility by helping develop small team-oriented family practice clinics in outlying concentrations of population. The Appalachian Regional Commission (ARC) had similar objectives and agreed to provide funding to support the development of one such clinic, the Lisle Medical Arts Center. The Center serves Lisle and several other small towns comprising a total population of about 16,000. One objective of the project was to enable study of the feasibility of a multidisciplinary private practice health care team in a rural area.

Program Development and Operation

Program funding support started in 1974. There were four staff members at that time: a local family physician who had been in solo practice in the area for many years; a second family physician who moved into the area to join him; a master's-degree social worker and a nurse practitioner. A third family physician and a part-time nurse practitioner have since joined the team.

At present the social worker's salary is paid out of the ARC grant. Out of a 45-hour working week, he spends about 25 hours counseling patients in relation to their psychological problems. Typically patient service episodes comprise about six office visits averaging 45 minutes each.

Of the patients, 95 percent are female. At present about 40 percent of the patients are referred by the Center's doctors; about 15 percent are referred by the Center's nurse practitioners; about 10 percent are referred by various community agencies and about 35 percent are self-referred. (The latter proportion has increased considerably in recent months.) The usual social work fee is $25 per clinical hour. This fee is negotiable downwards for the small

minority of patients who feel they cannot afford it. All fee income goes into the Center's general funds and the social worker receives a fixed salary. About 10 percent of the patients are able to recoup some or all of their fees from private health insurance companies. Over a third of the patients are covered by Medicaid. For these patients, 20 percent of the usual fee is reimbursed by Medicaid.

At present cash income from social work fees amounts to approximately 77 percent of the total of the social worker's salary and the program overhead expenses.

Assessment and Prospects

Doctor/social worker teamwork has been a key aspect of the Medical Arts Center since its inception. At least three favorable predisposing factors can be identified. The original grant writer--the assistant administrator of Johnson City Family Health Center--was a social worker by training and well aware of the usefulness of social workers in primary health care settings.

Secondly, the Medical Arts Center grew out of the practice of a physician who has a teaching associate in the Johnson City family practice residency--a residency which demonstrates and emphasizes the roles of social workers in family practice. The physician was thus receptive to the idea of working closely with a social worker in his clinical practice. The two other physicians who have joined him have come on the understanding that inter-professional teamwork should be an integral part of the Center's operating philosophy.

Thirdly, the Appalachian Regional Commission was favorably disposed to a proposal which emphasized teamwork and holistic care being made available to part of its Appalachian constituency.

The three years of ARC funding support will terminate in February, 1977. Already the social worker/physician collaboration has been judged a success by all concerned, and it will definitely be continued after the termination of ARC salary support. At present the social worker and the doctors are in the process of working out the internal contractual arrangements that will pertain after the cessation of ARC funding.

THE BOOTHEEL PROGRAM

Program Setting and Antecedents

The Bootheel Program was designed to serve the people of the Bootheel, a six-county, 3,376 square-mile region in the extreme southeast of Missouri. It is a fertile flood plain on the west bank of the Mississippi River. The main crops, cotton and soybeans, are produced mostly under the share-cropping system. At the 1970 census the Bootheel population was approximately 160,000. The region is steadily depopulating and economically depressed. Many itinerant farm workers move into and out of the area on a seasonal basis.

The Bootheel has approximately 56 physicians per 100,000 population, about a third as many as the national average. The poverty of the area compounds the problems caused by the health care shortage--many residents are unaware of the few existing health facilities and/or lack the necessary transportation to avail themselves of these services.

The Delmo Medical Social Service Program was one of many programs that have been initiated by Delmo Housing Corporation (DHC), a philanthropic organization formed several decades ago to house tenant farmers displaced from plantations. More recently its activities have focused on activism in the health care field. However, no physicians are on the full-time staff of DHC.

In 1972, DHC secured federal (DHEW) start-up funding for Delmo Family Health Services (DFHS), a foundation-type prepaid primary health care organization. Under individual contracts with DFHS, an extensive network of Bootheel physicians use their own offices to provide DFHS members with covered services. They do this on a part-time basis, while continuing their fee-for-service practice for non-member patients. By mid-1976, DFHS had over 7,000 members and contractual arrangements with over 100 doctors, some in solo practices, some in group practices.

In 1974, DHC decided to seek extra federal funding to hire a medical social worker. This decision can be attributed to a complex of at least four antecedents. Firstly, DFHS was considering development towards formal HMO status in order to qualify for federal assistance under the Health Maintenance Organization Act of 1973. One criterion for HMO status was the provision of medical social services. Secondly, no professional medical social services were then

available in the entire Bootheel area, and DHC was interested in pioneering such services on behalf of both DFHS members and other residents. Thirdly, the DHC Board as a whole had been impressed by the performance of social work students who had participated in earlier DHC community organization programs. Fourthly, two Board members were social work professors with an interest in promoting the development of social work services in the area.

Program Development and Operation

The second federal funding application was approved in mid-1974, and a one-year start-up program grant was provided by Memphis Regional Medical Program. Subsequently a six-month extension was granted. Under the grant, a master's-degree social worker was hired and equipped with a generous travel allowance. She worked out of DHC's office in Lilbourn (population 1,100). This office is located in the central part of the Bootheel.

The program objectives included demonstrating the opportunities for rural community-based medical social work; assisting in providing more comprehensive care to patients; promoting community understanding of comprehensive health care; and helping to increase the time that primary care physicians could devote to care related to acute physical complaints. The grant included provision for an outside evaluation of progress towards these objectives.[10]

The social worker spent most of the first three months familiarizing herself with her territory, attending meetings of various health-related community agencies, and publicizing her own program. Her publicity efforts included sending a promotional leaflet to all DFHS physicians. By the third month her various activities began to generate demand for direct counseling services, and this demand steadily increased until the tenth month when it leveled off at a volume which took up about 45 percent of her working week.

During the first twelve months of the program, the social worker provided direct services to about 100 families, averaging about three fifty-minute contacts per family. Mostly her contacts were with younger women. Twenty percent of patient contacts took place in her office; 15 percent on the telephone; 12 percent in Bootheel hospitals (none of which have their own professional social worker); and 53 percent took place in the patients' homes. The scarcity of both public and private transportation led to the necessity of so many home

visits. Considerable driving time was involved--some patients lived fifty miles from her office.

Despite her efforts to publicize her program amongst physicians, during the first year only four patients were referred directly by physicians. Most patients were referred by DHC or DFHS administrators or by the staff of other community agencies.

In addition to individual counseling in relation to psychosocial problems, the social worker organized weekly groups which brought together community residents for discussion of sex education, home economics, etc. She also provided much-needed leadership and consultation to community activists concerned with welfare rights and dental and housing facilities.

In April, 1975, DHC signed a service reimbursement contract with the Southeast Missuri Home Health Care Agency. This federally-supported agency wanted to expand its services to include social worker home visits, but did not have sufficient funds to employ its own social worker. Under the contract, DHC received an $18 per visit reimbursement for each home visit made by its social worker to the home health care agency clients. However, these reimbursements never totalled more than $200 per month.

Assessment and Prospects

During the first program year, satisfactory progress was made toward three of the program objectives outlined above--i.e., thsoe concerning demonstrating opportunities for social work service; contributing to comprehensive care; and promoting community understanding of comprehensive health care. The fourth objective listed above was helping to increase the time that primary care physicians could devote to care related to acute physical complaints. The expectation behind this objective was that physician-to-social worker referrals would result in the social worker being able to relieve physicians of some of the portion of their workloads previously devoted to counseling patients with psychosocial problems. In fact, only four patients were referred by the Boot-heel physicians. Further, any indirect time-saving effects of the social worker's activities were considered to be negligible. Thus progress towards this latter program objective was assessed as virtually nil.

The situation did not change significantly during the six-month funding

extension allowed by the Memphis Regional Medical Program (MRMP). Because of federal funding agency reorganizations, MRMP discontinued funding at the end of 1975. No alternative funds could be located and the income from the home health care contract fell far short of the amount needed to balance program costs. In January, 1976, the social work program was suspended indefinitely. The social worker has now obtained another job in the area.

The prospects for revival of the program are very uncertain. It is possible that if DFHS continues to expand and prosper, its directors may consider hiring a social worker out of regular membership dues. This is particularly likely to happen if some DFHS physicians become interested in an interprofessional teamwork approach to primary health care. Such interest may be stimulated by the increasing visibility of social workers in other types of agencies in the Bootheel, e.g. in housing agencies.

PROGRAM COMPARISON AND DISCUSSION

Both the Appalachian and the Bootheel programs have provided valuable service to their respective communities. The Appalachian program enjoys significant physician involvement and endorsement, and it is continuing. The Bootheel program failed to involve physicians in collaborative teamwork, and it has been suspended.

The success of the Appalachian program stems from the social worker's initial and continued status as a welcomed, invited guest, and as a peer professional within the Center. This status relates back to the founding physician's favorable experience of collaborating with social workers in the teaching clinic where he worked part-time, and to his subsequent enthusiasm for prospective physician-social worker teamwork during the time the Medical Arts Center grant proposal was being written.

A Californian program described by Guillozet has certain interesting similarities to the Appalachian program.[11] In King City, California (population 3,700) there is a long-established and stable ten-physician fee-for-service private group medical practice, the Southern Monterey County Medical Group. The group serves a socioeconomically diverse population of about 25,000, covering approximately 2,000 square miles. Prior to 1970, the nearest regularly available professional counseling services were located in a town 50 miles

distant from King City. In accounting for the Group's readiness to remedy this situation by working with a social worker, Guillozet wrote that "perhaps the most important attidudinal factor among group physicians was the shared belief that the lack of accessible mental health counseling resources for the community handicapped their clinical practice through their inability to procure these services for patients and families."[12] The physicians had had no significant prior exposure to social workers. Their decision may be characterized as a "third try" after disappointing experiments involving clinical collaboration with psychiatrists and a psychologist.

Starting in 1970, one day per week of on-site social work service was provided by social workers from the county mental health department. The social workers remained salaried by the county, and patients' fees (assessed on a sliding scale) were billed by the county. However, Guillozet emphasizes that the social workers were "invitees of the physician group."[13] They were provided with office space without charge. A particular group physician had responsibility for liaison between the visiting social workers and Group personnel.

The program became highly successful and by 1974 seven worker-days per week of social work service were required by the Group. Referral agents included physicians, high school personnel, ministers, and patients themselves. Team case conferences and consultations became part of the team's work style. "For the social workers, the blend of socioeconomic and social levels and ages provided interesting work experience which they judged to be less tiring than the more homogeneous patient groups seen in the large urban clinics."[14]

The Southern Monterey County Program is an example of successful outposting of county social workers into a private primary health care agency. General emulation of this type of arrangement is likely to be hampered at present by the budget restrictions and staff shortages characteristic of county mental health agencies in many parts of the country. However, such arrangements may be feasible in areas with particularly favorable geographical and political characteristics.

In comparison with the explicitly *invitationary* nature of the Appalachian and Southern Monterey County programs, the Bootheel program may be described as essentially *superimposed* by an external agency whose policies were evolved by non-physicians. It is true that certain Bootheel physicians did

endorse the program during the grant-writing stage, but their support was an expression of broad philanthropic attitudes rather than of commitment to close personal teamwork. In any event the volume of physician-to-social worker referrals was negligible. Probably much of this lack of teamwork development stemmed from the social worker having her office separate from the physicians' offices and geographically distant from many of them. Certainly this seriously thwarted opportunities for inter-professional interaction.

However, the inter-professional clinical teamwork component of the program would probably have fared little becter even if the office location handicap had been removed. This view tends to be supported by the experience of a rural Alabama program described by Garrett, Miles, and Lebaron.[15] The Lawrence County Health Care Project was launched in 1971 as an extensive federally-funded demonstration program to expand and broaden the availability of primary care. The original design called for a demonstration team consisting of a social worker, a public health nurse, and a physician's assistant to be added to the office staffs of each of five solo practice physicians in Lawrence County, Alabama. The physicians agreed to receive the teams at no cost to themselves, but had little input into the design of the project. There was "considerable role confusion and territorial struggle" between the three types of workers. The social workers found work in the community that needed doing, but after 18 months, "less than 5 percent of the social workers' patient contacts showed evidence of team effect in terms of the patient seeing other providers." However, there was evidence of demand for local social work services to be delivered under the sponsorship of the community hospital and the area community mental health center. The social workers were re-located on the basis of this demand pattern, and in 1975 the hospital assumed responsibility for funding its new social service department, thus assuring the continued availability of medical social work services in the county after the cessation of federal funding. Although the Lawrence County project has developed roots in the sense outlined above, it has not proved viable in the sense of establishing social worker involvement in the solo physicians' practices.

To summarize the argument thus far, this writer contends that the Appalachian and Southern Monterey County programs have become established as viable clinical primary care programs because they were originally *invitationary* in nature; the Bootheel and Lawrence County programs did not achieve this type

of viability because of their essentially *superimpositionary* nature.

Strategies for Program Innovation Advocacy

For those interested in promoting the development of social work programs in rural primary health care, what guidelines can be drawn from these program analyses?

The answers to this question depend to a considerable extent on whether or not the projected programs are intended to become independent of outside support. If this is not a crucial aim, then there is a scope for a relatively diverse range of strategies, including the development of superimpositionary and outposting programs as illustrated above.

However, in the current era of accountability and tight budgets, the writer considers that programs intended to become independent of outside support will represent the major growth area in the forseeable future. The remainder of this discussion will be concerned with this latter program category. For such programs, the invitationary style of innovation will be the norm. However, such invitations will often need to be solicited from prospective host physicians. This will involve program innovation advocacy which may be focused at several levels--local, county, state, etc.

Local Level Advocacy

At the local level, program advocates may be looking for a job for themselves or on behalf of their colleagues. They may already be working at another job in the locality, and if so they are fortunate in already having a source of income and a local platform from which to gather formal and informal information on local human service agencies. In view of the necessity of being on the spot in order to carry out this vital preliminary step, program advocates not yet resident in their prospective rural work area may need to seek interim employment in established local agencies such as hospitals, nursing homes, public welfare agencies, community mental health centers, health planning agencies, educational or correctional establishments, etc. Eventually they may decide to work part-time in such agencies and part-time in rural primary health care.

Once thoroughly familiar with the local human service network, and the gaps within it, the next step in program advocacy is to locate prospective

program enablers, i.e., persons likely to be instrumental in generating invitations to social workers to join primary health care agencies. Likely enablers include practicing physicians who are also clinical adjunct professors in nearby primary care residency programs employing social workers; recent and prospective graduates from such residency programs; primary care physicians and administrators whose educational background has included emphasis on inter-professional teamwork; ex-colleauges of physicians already working with social workers; etc.

Once some prospective enablers have been identified, they remain to be convinced of the value of social worker collaboration. This will usually require good marketing skills. There is a need for specific educational preparation in this area.[16]

Study of the operating style of drug company salesmen suggests some relevant strategies.[17] A successful "detail man" is able somehow to wheedle himself onto a busy physician's office visit schedule. His sales pitch is finely tuned to make an impact even if he is given only five, ten or fifteen minutes of the physician's time. He is never without a supply of free samples. Likewise, social work program advocates will need similar qualities of persuasiveness and economy of presentation. Furthermore, the free sample analogy merits serious consideration. The provision of free demonstration counseling services on a voluntary basis may be the only way to persuade some physicians to enter into an ongoing contractual agreement.

The professional isolation experienced by many physicians in rural areas --especially solo practitioners--lends particular cogency to an argument that may be used by program advocates. It concerns work overload. When the doctor is the only human service professional in a small town, it is hard for humanitarian reasons for him to refuse to take on the psychosocial problems of his patients--however disinclined, unqualified, or hard-pressed he may feel. In any case he may have learned from bitter experience that the preventive approach does pay off, that problems ignored on first presentation tend to recur later in a more intransigent form. Thus many isolated physicians are drawn into a pattern of overwork, furstration, and exhaustion--conditions too often exacerbated when a nearby colleague succumbs to the pressures and joins the rural physician exodus, leaving his patients to seek care from the few physicians who remain. Furthermore, the prospect of such an undesirable workstyle tends to deter many young physicians from setting up practice in rural areas.

Addition of a social worker to a rural practice can radically change the outlook. The psychosocial workload can now be largely handed over to the social worker. The physician can provide less hurried and more thorough care. Physician-patient relations are likely to improve. Furthermore, the physician is provided with the stimulation of frequent interprofessional dialogue.

Because of economic considerations a one-to-one team ratio is unlikely to be viable if the social worker is full-time. However the success of the Appalachian program has shown that in a small family physician group a three physician/one social worker ratio is viable. Alternatively, a social worker rotating weekly between three (or more) solo physician offices could well be a viable work-style in rural areas. In such circumstances the social worker's renumeration could be made up of several part-time salaries. Alternatively, it could be an agreed percentage of the social worker's patient visit fees (the remaining percentage going to each physician to defray overhead--office maintenance, reception and secretarial expenses, etc). Caccamo has described an arrangement between a solo internist and a part-time social worker, under which the social worker's income consisted of her fee income minus an overhead levy of approximately 20 percent.[18]

The development of such arrangements may help attract young physicians to practice in rural areas. Currently many residency programs--especially family practice residency programs--lay strong emphasis on the merits of interprofessional collaboration. If such collaboration is seen to be possible in a rural primary health care setting, this consideration may persuade some young phsyicians with tentative interests in rural practice to actually give it a try. Given the acute shortage of physicians in many rural areas, this influence would represent an important indirect benefit of social worker participation in rural primary health care.

Other Levels of Advocacy

Advocacy focused at levels other than the local one will rarely result directly in broad-scale program innovation, but such advocacy may be instrumental in improving the attitudinal climate so that local advocacy can be more effective. Presentations by social workers at county medical society meetings are examples of county level advocacy. Advocacy at the state level may be concerned with the vendor status issue--i.e., promoting state social

worker licensing bills that tend to enhance the prospects of social workers being recognized as independent professionals by health insurance companies. In fee-for-service primary health care settings, a physician's assessment of the viability of a proposed collaborative arrangement may turn on whether or not his patients will usually be able to claim health insurance reimbursement for fees for social work services.

Two Final Caveats

In closing, two cautionary notes should be sounded. Firstly, in rural primary health care settings movement towards program innovation and development will require a slow and delicate tread. Rural people only slowly accept new programs and new personnel. The route to such acceptance will be fraught with difficulty and challenge. Kiesler's description of such difficulties, based on experiences in rural mental health care, is likely to apply equally to rural primary health care settings:

> "Not only our personal attributes but also our interests, our life styles, our drinking habits, our marriage, our children, our religious practices, our politics and our positions on various issues of current concern had to be catalogued before we could become personally predictable enough to be trusted with more than technical questions. Only when professionals have lived in rural areas long enough to emerge as citizens with as much personal stake in the future of the community as anyone else can their communities make full use of their capabilities..."[19]

Secondly, when extolling the merits of the establishment of social worker participation in primary health care, program advocates should not fall into the trap of ignoring, or being perceived as ignoring, the natural lay helping networks that are traditionally particularly strong in rural areas. Such networks are the very fibre of meaningful society--we usurp them at our peril. In fact, social workers should go out of their way to preserve, assist, and stimulate such networks.[20] It is the people who fall through the networks who may need social work services.

FOOTNOTES

[1]The writer thanks the following persons for their assistance with the preparation of this paper:

Susan Bekenstein, University of Illinois, School of Social Work, Urbana, Illinois; Alex Cooper, Delmo Housing Corporation, Lilbourn, Missouri; Ronald Kissick, Lisle Medical Arts Center, Lisle, New York; David Miles, Lawrence County Health Care Project, Moulton, Alabama; Emma Walker, Hayti, Missouri; and Edward Watson, Rural Health Project, King City, California.

Preparation of the Delmo program discussion was supported in part by USPHS Grant No. 5 G03 RM-0051-06 from the Memphis Regional Medical Program. However, the contents are solely the responsibility of the writer and are in no way the responsibility of the Regional Medical Programs Service, the Public Health Service, or the Dept. of Health, Education and Welfare.

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5 THE USE OF NEW TECHNOLOGY IN RURAL HUMAN SERVICES

There has been a tremendous increase in technological innovations within the past thirty years. While the new technology was often developed and designed for fields far removed from human services, rural human service practitioners and educators have often been highly skillful and resourceful in "scrounging, begging, and borrowing" technological advances for adaptation in their programs. The next two papers, illustrating how the telephone can be used to provide consumer health information, and how radio technology can be used to improve field communication, are typical examples of rural creative thought.

DELIVERING HEALTH INFORMATION TO RURAL AREAS THROUGH USE OF SHORT, TAPED, LAY-ORIENTED MESSAGES

Marjorie Bartlett

The Problem

Health or our degree of feeling well directly affects how effectively we do our jobs - whether that be studying, home making, teaching, in industry, on the road, in the field - whatever we do, wherever we do it! Little wonder that we greet each other with a hopeful, "How are you?" How we feel also affects how we interact with others. The person who doesn't feel well can't be interested in persons and things outside of himself. Everything becomes a chore, small annoyances become great obstacles, irritability and short temper characterize the personality. Very obviously, the maintenance of an optimal state of health is a major concern for all who are involved in social work. Hardly any aspect of social work is not, in some way, involved with health.

In years past, the medical profession was predominately illness oriented. Now, we hear more physicians echoing Dr. Theodore Cooper, Assistant Secretary for Health in the Department of Health, Education and Welfare, who, speaking before Congress and the President stated that the key to better health is to take better care of yourself. He said, "Much improvement in health status could come from individual action."

The Governor of Wisconsin, in May of 1971, appointed a Task Force on Health Planning and Policy. In doing so, he expressed his belief that everyone has a right to health care and that the state and its citizens must make this a reality for all persons in the state.[1] He went on to say, however, that "the state does not have the resources to help all people pay for their medical care. We must all maintain our own health." In the list of Task Force recommendations resulting from this study, the fifth, sixth and seventh items in a list of 39 were, in some way, concerned with health education.

Clarence Pearson has stated that, "Today the emphasis on consumer education and protection gives added impetus to programs that call attention to effective health and safety practices. Now, perhaps more than ever before, the individual must learn how to use the resources of modern medical science

effectively and efficiently. He must be helped to acquire a greater sense of personal responsibility for his health and to change many of his living habits in order to enhance his chances for a long and health life.[2]

The health needs of persons living in rural areas are the same health needs of all of the people of our state or country - only the means by which these needs can be met may be different. Persons living in rural areas have heart problems, over-weight problems, accident possibilities, safety concerns, just like persons living in other places. Of course, ski injuries and snowmobile accidents are less prevalent in Modesto, California. Actually, most of us realize that persons living in rural areas have a history of being medically self-sufficient. In the early days of the western movement, the wife and mother was midwife, surgeon, and general doctor for all the famliy ills. Women became specialists in ways to remove arrows, treatment of snake bite, fever, broken bones, and injuries. Trained physicians were scarce. A much used story has an early settler remarking during an epidemic, that four of his children had already died that week, now his wife was sick; and if it kept up much longer he was going to have to send for the doctor!

Also, it is quite probable that, collectively, rural persons may be more family oriented than those living in the large cities. Increasingly recognized is the role of the patient *and* his or her family in the promotion and maintenance of family health. R. W. Jamplis states, "The major burden involved in chronic illness, or in the prevention of disease, often falls on the patient and his family."[3] G. G. Reader feels that, "the family of the patient constitutes an important factor in whether the patient is likely to comply or not, so that education of the family becomes part of the overall plan. If the family is supportive and understands what is required, they can often make the essential difference between a noncompliant and a compliant patient."[4]

In an era when health care can be very expensive and, in rural areas where travel to a health care facility can be consuming of time, money, and gasoline, it is ever more important that rural areas have access to resources which will help reduce the need for professional medical assistance. E. Fehlberg has said that, "the only solution to the high expense is to personally monitor health and seek medical consultation before hospitalization is necessary." Her opinion is resounded by many. She also sees maintenance of good health as a commitment and a personal responsibility.[5] L. Lamberg states, "Doctors and laymen alike

are starting to insist that patients and their families take more responsibility onto themselves by engaging in self-help and preventive medicine programs. A medically knowledgeable public is essential if this movement is to be successful."[6]

Any increase in the ability of the individual to assume a greater responsibility for his own and his family's health must depend upon the ability of the individual to become knowledgeable in matters pertaining to health. The basic facts upon which good health maintenance can be built must become readily and inexpensively available to everyone. N. H. Bryant feels that, "non-physician members of the health team will have more opportunity to participate more fully in patient care."[7] Renner advises us that, "a great deal of your effort may involve readjustment of prior knowledge."[8]

For most lay persons, formal health education has been minimal. We may learn some facts (and maybe a few non-facts) in school, some first aid in scouting, and end up getting most of our information regarding sinuses and stomachs from the TV commercials and most knowledge about contraceptives from magazines. Who is responsible for making health education available to the public? Here we should divide the process into two parts: production of materials or programs. The first is essentially easier than the latter. Wherever people interface with resources, learning can take place. The closer the resource is tied to the delivery method the more effective the learning may be for the majority of people. Dale, in discussing the effectiveness of presenting material via various media, shows us that the closer the learning resource is to the fact of the material to be learned, the more meaningful it will be to the greatest number of people and to the individual. By illustration, the most effective way to teach a child that if he plays on the railroad tracks a train may run over him would be to let him play on the tracks, and let a train run over him amputating his leg. That would be a lesson learned and not forgotten. His little friend, wathcing from the side-lines would share the experience vicariously, and his learning experience might rate #2 on an effectiveness scale. Seeing a reenactment of the scene on the stage, in the movies, on TV might all rate as a #3, #4, #5 experience. Hearing the story on the radio or over the telephone might rate as a #6 mode, while reading about the incident in the newspaper with a picture could rate a #7, without a picture a #8, and reading about this safety hazard in a black and white brochure with small type might rate a #9 as an

effective learning mode.[9]

The Resource

When making the decision as to resource to be used and delivery method most desirable, one must measure cost as related to effectiveness level and possible number of people reached. There is much to be said for employing many different types of delivery systems in an attempt to reach those persons who might most comfortably and profitably access that system. That is why health education has a place in girl scout skits, Rotary Club programs, radio spots, TV specials, University Extension bulleting, professional journals - wherever it can interface with a person where he is in his normal pattern of living. It has been my experience that people will not go far out of their way or pay admission to health education resources. The resource must be readily and easily accessible.

HEALTH-LINE is a health education resource which has been developed by the University of Wisconsin--Extension Health Sciences Unit Department of Continuing Medical Education and the Univeraity of Wisconsin--Madison, Center for Health Sciences.[10-11-12-13] The resource itself consists of a growing library of about 360, four to five minute, lay-oriented taped, health related, messages, multidisciplinary in scope. The tapes are usually prepared in cassette form with the same message on each side, end to end, so no rewinding is necessary. Topics include subjects of interest to the person in the community with emphasis on good health maintenance, preventive medicine, safety, emergency care, health topics for parents, some health messages for children, advice concerning when in the course of a health problem one should consider seeking professional help, and home care of chronic illnesses. About 23 messages are available in Spanish translation. Scripts are prepared by personnel knowledgeable in the topic areas, are reviewed by authorities in the subject area, and are approved by the project director. Cyclical review assures that each message is reviewed at least every three years. Most messages are reviewed more often as their content is prepared for a radio presentation, TV or other use.

Telephone access to short, taped, health related messages has a number of advantages which can support this as a basic medium upon which to build a comprehensive program for consumer health information and education. Many of the same advantages are maintained when taped messages are used with a hand-held

playback unit.

1. The system can provide the information needed at the time it is needed from where the recipient is located.
2. Messages can be made available to a very large number of people, relatively inexpensively.
3. The anonymity of caller is preserved. No one knows who called to hear a specific message and no one knows what the caller is hearing over the telephone or with the earplug on the hand-held playback unit. Some people would feel much more comfortable hearing a phone message in relative privacy about the use of a contraceptive than being seen reading a pamphlet about the same subject, or seeing a videotape in a library or other public place.
4. Audiotapes tell the story in proper sequence and are a definite advantage to the poor reader or the person who just doesn't care to read.
5. In the hospital setting, patients are often on medications (tranquilizers or pain relievers) which may cause visual problems such as blurring thus making reading difficult.
6. Certain people learn best by listening.
7. Credibility can be obtained by the friendly tone of the voice on the tape and through maintenance of a telephone conversation mood, using the first and second person instead of the traditional, "the patient will..."
8. Techniques such as interviews, talks between a patient and her physician, and even short skits for children have all been successfully used to increase listener involvement.

Methods

At the present time *HEALTH-LINE* messages are being used by: 1) hospitals and clinics which subscribe to the Madison-based library, by 2) purchasers of the messages either a) in their own playback centers, or b) by use with hand-held playback machines, and 3) by various communities in Wisconsin which receive service via Extension Educational communications systems link-ups.

Utilization

Wilkenson, Mirand, and Graham have been providing cancer messages by telephone in upstate New York.[14] Their call log studies reveal that there is a decrease in usage of the systems from urban to suburban to rural areas based on calls per 10,000 population. A promotion campaign obliterated this difference and it was ascertained that poor response was probably due to lack of awareness

of the program. Lower usage was found among the elderly, males and persons in the lowest socio-economic stratum. This type of response was corroborated by our unofficial observations of usage within the hospital environment.[15]

Barriers to Utilization

Educators recognize that there are barriers to communication some of which may be: language, age, educational level, cultural level, social class, occupation, race, fear, anxiety, illness-regression, current status of knowledge, need for unlearning incorrect information.

As *HEALTH-LINE* messages are prepared, we try to be cognizant of these barriers so that messages are widely applicable. We must be careful not to talk down to the educated nor speak above the heads of the relatively uneducated. The greatest barrier is not knowing the service exists. Constant promotion is necessary to inform the public that they have access to the resource.

Thompson divides every communication exchange into four basic components: 1) the sender, 2) the receiver, 3) the message, and 4) the medium.[16] Undoubtedly, the environment within which the message is received can affect the effectiveness of the medium. A motion picture which is out of focus or in a too bright room, a telephone voice too faint or too loud, extraneous noise from passing traffic or loud music, hurry, anxiety, or a terrible headache - all may diminish the level of communication. Some of these factors can be controlled, some cannot.

Delivery System

In using the telephone as one of the ways of delivering health messages, *HEALTH-LINE* has recognized that telephone service is now readily available in most areas. In Oneida County, for example, telephone service is available via two companies. Service is available anywhere in the county and subscriber rate is high. A telephone company official has told me that the person most likely to be a non-subscriber would be male, living alone in a rural area.

In a report by Wilkening on the "Quality of Life and Development in Northwestern Wisconsin," nowhere is there documented and dissatisfaction with or need for telephone service in these eight counties.[17] Need for increased health care, physicians, and medical facilities are quite high on the list of

problems to be solved.

Availability of *HEALTH-LINE* Service

At the present time, *HEALTH-LINE* service is available in about a half dozen locations in Wisconsin either via subscription service or via extension programs in which extension may cooperate with various community organizations. It is hoped that, within five to seven years, all persons in the state will have access to *HEALTH-LINE* messages over FX lines into area centers or via an IN-WATS line in areas not served by the former. The UW--Extension Instructional Communications System is currently planning its service expansion toward this end. Extent of usage of the service where it now exists can influence the speed with which expansion proceeds. The dominant factor will be how much money becomes available each year for expansion purposes.

Each service center does not have a complete *HEALTH-LINE* library. Hospitals and other institutions which may wish to have additional messages or individualized messages added to the local library may purchase them from *HEALTH-LINE* and place them in the local library.

Individual *HEALTH-LINE* cassettes are available for purchase by schools, clubs, and other institutions desiring them for in-house usage. This year the Wisconsin Hospital Association Auxiliary Health Education Project is encouraging the auxiliaries to help their hospitals acquire *HEALTH-LINE* messages for use within the hospitals or donate to the area library specific messages of interest to hospitalized patients or to hospital personnel.

For utilization outside of Wisconsin, *HEALTH-LINE* messages may be purchased for use in a central playback system or with hand-held playback units. All information and catalog will be supplied on request.

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RADIO COMMUNICATION IN A RURAL SOCIAL WORK SETTING

Thomas Keith

Radio communication is not a new idea. Police and fire departments, conservation and military personnel have been using this means of viable communication for years. Yet social service agencies have only recently turned to this source of communication to serve as an extension of their agency communication system. I personally feel that radios do have a place in social service agencies, especially agencies serving rural areas, such as northern Wisconsin counties. Many times blizzards knock down power lines and telephone lines leaving vast areas of counties without any other means of communication. During the summer months, tornados and electrical storms also knock out communications. With radio communication, an agency can have a base unit at the site of their office and mobile units installed in the automobiles of their social workers or homemakers who are to provide service. Thus, as long as they have electricity at the site of their agency office to operate the base station, either through normal electrical line service or a portable generator, they are free to operate independently of the elements. It is not necessary, however, to install radio communication only for the thought of emergency services. It is a valuable communication device for normal agency related business.

When one considers radios as a source of communication, there is a broad scale of various types of units to choose from. Depending on their choices, all have positive and negative factors to be considered. I will attempt to elaborate on the alternatives of these choices. The decision as to which type is ultimately used is up to your particular needs. Before dealing with type of equipment, I feel there are several points to be considered in the selection of the particular unit you may eventually use.

First, do you wish around-the-clock access to communication via radio such as for the provision of emergency service? Do you desire only that communication services be available during normal agency working hours?

Second, one must consider that depending on the type of equipment you choose, the problems of confidentiality arise. Some networks have closed channels that are not normally monitored by the general public, whereas other such

units, such as Citizen Band radios, can be monitored by anyone with a like unit in the immediate vicinity. Thus, you must restrict the information which is given over the unit because of confidentiality purposes.

Third, you must know the terrain of the locality in which you are working. If the landscape is hilly, with many high points and low depressions, some units will not work as desirably as others. Depending on the terrain and the location of the base unit, a 100 to 200 foot tower may be required.

Fourth, the freedom of communication language varies with the particular type of unit and frequency which the agency may choose to operate on. Everyone is aware of the recent increase in Citizen Band radios and the jargon which is used by their operators. Citizen Band radios are almost unrestricted in communication which may be transmitted over them with the exception of the prohibition of vulgar language. High or low band radios, which are granted license to operate under federal communication system regulations however, are much more restricted. There can be no usage of such networks for personal reasons, they must be used strictly for business purposes. There are strict requirements for signing on and off the airway promptly after useage of such bands, and any violation of such regulations may result in revocation of the license to operate.

Now let's look at the types of units available. We have been referring to Citizen Band radio units, better known as CB units. Licenses to operate these units are easily obtained. Such units run in price from $100 to $200 for a mobile unit. They are reasonably compact and can be readily installed in most automobiles. Including the installation and antenna, an average unit would run approximately $150. A base station for Citizen Band units varies from $200 to $300 in cost, and must have an accompanying antenna of desirable height to cover the area to be served. Generally, with a 50 foot tower, such units are limited to 30 to 50 miles or so in range of communication from tower to mobile unit and return under ideal conditions. A CB unit broadcasting from an automobile to another automobile is limited under the most ideal conditions to approximately a ten mile radius.

It is in dealing with Citizen Band radio primarily, that one must remember the issue of confidentiality. Citizen Band radio units are open frequencies available to the general public for radio communication usage, Thus, there is no assurance that the channel on which the agency may be operating is solely

available for agency work. Persons using such equipment must keep the issue of confidentiality in mind and restrict the useage of names and other personal information concerning the person or party they are making reference to via such communication networks. This sometimes limits the effectiveness of utilizing Citizen Band communication for social work purposes. Citizen Band radios however, can be used by social workers in their own private automobiles. In rural areas, they can be utilized in the case a social worker becomes stranded due to automobile breakdown, stalled in a snowbank or slides off a wet or icy road. There is a good chance in such cases that another CB operator in the area will be monitoring Channel 9, an emergency network established by law on the CB frequency. In such case, if the person monitoring the network picks up their call they can relay via phone in order to dispatch the necessary assistance which may be required by the social worker in distress. Thus saving the worker a possible walk of some distance in sub-zero weather or adverse conditions as they would have had to have done in the past.

The next method of communication is sometimes referred to as a paging unit. The paging unit is a small compact device which can be operated on a high or low band radio frequency. Such items can be left on for an extended period of time with little drain on the unit's battery, or maybe connected by an adapter to a regular electrical outlet in the worker's home for example, and left on continuously to receive incoming calls. A paging unit can be used to receive calls from a sending base but the worker may not return a call through the unit to the base. Instead, the worker must seek out the nearest telephone and respond to the base station via that media. This does serve to offer some limitations in cases of telephone failure as a result of a storm, etc., where the worker could not report back to base if it was necessary to do so. This device is presently being utilized by the Polk County, Wisconsin, Department of Social Services for their emergency service workers who are on evening and weekend calls. As there is not a dispatcher normally on duty in the Department of Social Services during evening and weekend hours, they have come to rely on the county sheriff's department radio frequency for dispatching of necessary emergency messages. They utilize two paging units which cost approximately $250 each. These units are given to the workers who are on stand-by duty for emergency services. The units can pick up radio signals to a range of approximately 50 miles from the base tower and can adequately serve the area covered by the County Department of Social Services. When an emergency call comes into the

sheriff's department during evening or weekend hours that necessitates social services, they in turn dispatch the call via their radio network which is then picked up by the paging unit in possession of the social worker on stand-by duty, be they in their home or automobile. The worker would then call into the sheriff's department acknowledging receipt of the call and then report to the scene to deliver what services may be deemed necessary. In this particular case, it serves the needs of the Department quite adequately.

Polk County, Wisconsin, Department of Social Services, as does the Burnett County Department of Social Services, uses mobile radio units in that they can operate only on an assigned frequency approved by the Federal Communications System. Depending on the particular unit, they may have from one to three frequences, however, they generally operate only on one frequency. This frequency is not monitored by the general public and offers a direct means of communication from the Department to the worker with a high degree of assurance that the confidentiality of such communication will be kept. The Wisconsin State Department of Health and Social Services, back in 1970, obtained authorization from the Federal Communication Commission for licensing of low band channel number 46.56, and Burnett County began participation and utilization of such networks with mobile radio units at that time as a pilot project. Since that time, the Polk County Department of Social Services has also joined the network and the channel is licensed throughout the state and available to any other county department of social services wishing to utilize this network. The advantage of this type of network is that the department has sole access to the radio frequency for its business purposes. With Burnett County and Polk County located adjoining one another, the agency may talk from agency to agency via radio or from agency to any of their mobile units in the field via radio. Social workers in the field if they are within ten miles of one another, can speak directly to one another from mobile unit to mobile unit; if they are beyond this distance, their calls must be relayed from their mobile unit to the agency base station, and then relayed from the base station back to the other mobile unit. This type of network offers direct contact during normal working hours with all social workers and the homemakers in the field. The agency can dispatch workers from normal routine service calls to emergency situations as they arise. In the past they would have had to dispatch another worker from the agency as in most cases, they would have been unable to reach the social worker or homemaker in the field once they had left the office for the day.

Social workers or homemakers can also be notified if a client calls in and is unable to keep a scheduled contact that day after the particular worker has already left the agency. This saves time and mileage on behalf of the worker and allows them to reschedule their activities to include an additional call on their daily schedule to compensate for same.

With this type of communication equipment, the average mobile unit runs approximately $800 to $900 in cost. A base station costs approximately $1500 plus the installation of an antenna and hilex cable and tower. As stated previously, depending on the terrain of the area in which the communication is operated, the height of a tower may vary. Generally speaking, a 100 foot tower will adequately serve an area and give a communication range of approximately 60 miles distance from the tower to the mobile unit receiver, under the most ideal conditions.

One of the disadvantages of this type of communication is already obvious, the fact that it can only be utilized during normal working hours when there is a dispatcher represented at the site of the county agency to receive and dispatch calls. Mobile units under this system may talk directly to one another after the normal working hours without the use of the base station, providing they are within an approximate ten mile distance from one another. This sometimes permits workers on emergency calls during evening hours, who are aware of each other's whereabouts and close enough to contact one another for assistance, to coordinate their efforts in the field. It cannot however, be relied on for such purposes, as one may not always know the location of another worker and whether or not they are in their automobile, or whether their unit is turned on. Of course, the distance from the center of the sending signal to that of the receiver is another factor which must be kept in mind. As stated earlier, this is ten miles from mobile to mobile relay. This type of unit, however, can be utilized in emergency situations such as severe storms, tornados, floods, etc., by sending an emergency dispatcher to the site of the social service agency to man the base unit during evening or weekend hours, and thus provide the communications necessary for all the mobile units operating in the field. This is part of Burnett County's policy for civil defense or emergency disaster situations as they arise.

Radio communication may not be for everyone. As already explained, the selection of equipment varies and does offer opportunity to select that

equipment best suited to a particular agency's needs. I dare say that if you try it once, you will like it, as the saying goes. My workers were reluctant at first to begin speaking over the radio, feeling insecure and intimidated. The same held true in the case of Polk County workers when they first began implementation of their radio communication services. You would never know the same workers today, for you can hardly keep them quiet once they have access to a radio. I dare say that the majority of the workers who have utilized two-way radio communication for any length of time would not wish to be without it thereafter.

Besides utilizing radio communication for normal office dispatching or routine calls, there are many occasions of emergency nature for which it becomes utilized. On one occasion, our homemaker calling upon an elderly gentleman in a rural area some three or four miles distant from the nearest phone line, found the man lying unconscious on his front porch in a drizzling rain. He was a very heavy gentleman and it was quite difficult for the homemaker to move him inside of the house and onto the floor. She then returned to her automobile, and via radio, contacted the agency to dispatch an ambulance. She was then permitted to return to his side and administer to his needs until the ambulance arrived. On another occasion, she called at the home of an elderly gentleman who had requested that she stop by the first part of the following week. He did not answer the door when she knocked and she noticed that the door was locked from the inside. She became alarmed and called the Department via her radio, at which time the director and social worker responded to her call, as they were in the area. After forcing the door, we found that the gentleman had died of a heart attack and was lying on the floor in one of the adjoining rooms. A call was made to the agency office for the dispatching of an ambulance and coroner. On other occasions, our workers in the field have come upon the scene of automobile accidents before any call has been made to report them. They have instantly called into the office, which in turn notifies the sheriff's department and, when necessary, an ambulance has been dispatched to the scene. Thus, the agency offers a form of community service in addition to its regular duties, which serves to improve public relations with the local sheriff's department, as these mobile units act as an extension in the field at such times of emergency.

All calls are not emergencies, however. Some of the calls, for example, justify the need for and installation of such equipment by the agency and serve

to offer proof of the overall time and transportation costs which a worker can save by the utilization of such equipment. In one instance, an elderly lady had been hospitalized for several days at a county hospital. Late one afternoon, her doctor authorized her to return home after completing an examination. The hospital called the Department of Social Services for transportation, for she was without relatives in the area. This hospital was located 25 miles southwest of the agency and the lady lived another 11 miles north of the agency. In normal times, the Department would have had to dispatch someone in the office to go and retrieve the lady, transport her to her own home and return to the office. This would have resulted in a 70 mile trip plus the services of an additional worker. With our mobile radio communication, we sent out a call for an available worker within the vicinity of the hospital. As luck would have it, a homemaker was returning from one of her contacts to the office, and was approximately three miles from the hospital at the time of our call. She reported in to the agency, went directly to the hospital, and transported the elderly woman home. She then returned to the agency. As a result, the agency saved the duplication of mileage and time on behalf of another worker via the simple relaying of a message over radio communication.

This is not an uncommon usage for radio communication in the social service department. On another occasion, the sheriff's department had picked up adult members of a family involved in an automobile theft and transported them to the county jail. They then learned that three of the family's small children were staying at a neighbor's home, which had no telephone communication. Because the adult members were to be incarcerated due to lack of bonding, the sheriff's department notified the Social Services Department of the circumstances and the need for an emergency foster home placement. Again the Department sent out a call via radio to a social worker who was working in the immediate vicinity of the home where the children were staying. That worker reported directly to the home to pick up the children, while the Department was arranging for the necessary temporary foster home placement and securing the papers required. By the time the social worker had picked up the children and was returning to the agency, all the arrangements had been made for the worker to proceed directly to the emergency foster home which was to be utilized. Again, a saving of time and transportation costs which would have had to have been duplicated by another worker if such communication equipment was not available to the Department.

Examples such as these are numerous in day to day operations. There are many more that I need not repeat here. I feel that radio communication is here to stay. The units are becoming more and more compact with the transistorization of such equipment, and as the demand increases, so does productivity, and the prices of such units generally become more reduced, thus, more easily accessible to the departments' budgets. Somewhere I'm sure there is a radio communication device suited to your agency's needs.

I have mentioned but three possible choices in this paper. There is more variety I am sure, and with a little inquiry you could become knowledgeable of them. I can only encourage you to review them all and make a selection as to which device best suits the needs of your agency. I am sure that it will enhance the ability of your particular agency to deliver social services in a rural area. I know, in closing, that my agency would not be without the assistance of such communication after having once utilized it.

6 DEVELOPING RURAL DELIVERY SYSTEMS

The following two articles deal with the overall development of rural service delivery systems. The first paper, prepared by practitioners and students, deals with how a public welfare agency in Iowa is attempting to reorganize to provide more effective services to its rural clientel. The second paper describes the social development perspective of the graduate school of social work at the University of Minnesota, Duluth, which advocates that human service professionals should attempt to develop new institutional potentialities for human service delivery systems rather than merely perpetuating the delivery of traditional residual programs and services.

A MODERN RURAL HUMAN SERVICE DELIVERY SYSTEM: AN IOWA EXPERIMENT

Lynn Dunn, Christy Albaugh, James Huber,
James Cline and Marcia Anderson

The Administrative Structure of the Iowa Department of Social Services

Prior to January 1, 1975, the Iowa Department of Social Services was administratively organized with Iowa's 99 countiesdivided into four regions. As of January 1, 1975, the state has been divided into 16 administrative districts. These districts are composed of from two to eleven counties. The Dubuque District which includes Cedar County, the focus of this paper, consists of three rural and two urban counties and comprises seven percent of Iowa's population. Each district is considered an entity for service delivery; therefore, expanded and cooperative services across traditional county lines are possible.

The District Administration of the Dubuque District is responsible for the administration of social service in each of the five counties in the district. Some counties have a single county director responsible for administering income maintenance and service programs; others have separate administrators for services and financial programs. The county as an individual governmental entity does not have administrative control over the local Department of Social Services. There is cooperation and communication with county officials. If the county's local poor fund (i.e. general relief) is distributed by the Department of Social Services at the county's request, the County Board of Supervisors act as the administrative unit for this fund. Salaries of employees and financial payments to clients are computerized and paid directly by the state.

The Cedar County Department of Social Services

The purpose of the Iowa Department of Social Services is to make available to the people of Iowa an array of financial and social services to prevent or reduce the incidence and/or effects of conditions which handicap and/or disadvantage the individual in society. The Cedar County Department of Social Services has long been concerned about the quantity and quality of human service. As one travels the major highways (I-80 and U.S. Highway 30) through this area,

a feeling of a very affluent region prevails. However, once off the major thoroughfares there exist strong contrasts between afluence and poverty in addition to isolation.

Since 1972, the public assistance and service caseloads of the Cedar County Department of Social Services have grown considerably--whether this is due to better outreach or increased needs, or a combination of both. It is obvious to see that much of America's urban crisis has roots in rural America. Since the rate of increase in usage of public assistance is higher in Cedar County than in some economically similar counties in Iowa, the increase in part is attributed to the agency's philosophy and practices.

The Cedar County Department of Social Services has made a deliberate effort to be non-punitive in its relationships with clients. Agency personnel believe that it is important to have a friendly attitude and be a client advocate. In fact, very few of the client appeals made concerning the agency's services are against workers--the majority of the appeals are made jointly by clients and workers against state regulations. The agency does not believe in rigid appointment scheduling. Other than home visits, the majority of clients are seen as they walk into the agency. The agency does not prolong the waiting periods when applying for assistance. In many counties, a client can expect a month's lag between application for aid and approval; whereas, in Cedar County, the average time between application and receipt of a check or food stamps by the client is one week.

Workers in the Cedar County office do not follow the practice of specialization of caseloads as other offices do. Each worker has knowledge of the total program, not just their own part of a program, and is able to work with a client from beginning to end, instead of having the client referred to two or three different workers with each change in type of service or assistance received. This contact with the same worker from beginning to end appears to be less threatening to the client. Willingness to take the time to listen to the client establishes a much better relationship with him or her and it is the feeling of the staff that this is more important than the "paperwork time" lost because of it.

The staff is willing to put in extra time on nights and weekends and to be contacted by clients during "off" hours. Recognizing that clients don't have

problems from only "8 to 5 on weekdays," the staff view their positions as professionals and more than "just a job."

Outreach is considered an important agency function. Reaching out to find people in need and meet them away from the physical boundaries of the office is considered meaningful to both the client and the community. The agency's staff feel that it is important to be part of and involved in the community. Community members who know staff members and know what they do are less reluctant to make referrals to the agency.

In a rural community, it is difficult to reach people in all of the outlying areas. With the limited number of agencies and workers, often being located in the county seat or the largest population center in the area, access to services decreases with distance into the rural area. Those in need of services are sometimes the ones the least likely to know that they even exist. With the added factor of the stigma attached to the usage of certain services in the rural environment, many persons are less likely to seek information on their own as to the availability of services. This is especially true in counties like Cedar, where helping agencies are housed in the courthouse with high visibility. Another area that is very important in the total agency functioning is the compatibility of all units and workers in the agency. There is no worker or unit alienation. Everyone is willing to cooperate with everyone else and is willing to help in crisis situations.

In all communities regardless of size, there are certain individuals who are more helpful in a general way than others, and thus are sought out by people when problems arise. These natural helpers can be in professional positions such as doctors or lawyers, but they can also be working people such as bartenders, hairdressers, and grocery clerks. The Cedar County Department of Social Services staff feel that these indigenous community leaders deserve attention and are seeking ways to integrate them into the rural human service delivery system thereby adding to the overall effectiveness of the system.

A Profile of the Area

In cooperation with the Clinton County Department of Social Services, a project is being implemented whereby six townships in Clinton County and two townships in Cedar County will be in a special project area.

The 1970 United States Census information gives this picture of these townships:

1. The area is 100 percent rural
2. Total population in the area is 6,677 people
   a. Thirty-seven percent of this population is under 20 years of age
   b. Thirty-seven percent is between the ages of 21 and 54
   c. Twenty-seven percent is over 51 years old

Occupationally, 25 percent of the employed population are farmers, while another 24 percent work as operatives (operators of large machinery). Twelve percent of the area population is below the federal poverty level, compared to only 9 percent of Tipton, county seat of Cedar County and 8 percent in Clinton, county seat of Clinton County.

By these simple population statistics it is easy to conclude that this geographic area is, indeed, sociologically, economically and philosophically rural in nature. Because of isolation and a culture built on agri-business, individuality, community awareness and few formal "social welfare" resources, alternative modes of service are needed in this rural area.

A Social Service Needs Assessment

Because of its close proximity to the University of Iowa and the Iowa School of Social Work, the Dubuque District of the Iowa Department of Social Services has utilized graduate students from the School of Social Work to conduct a "needs" survey to identify the social service needs in this rural mid-eastern Iowa area.[1] Focusing on the eight selected townships where services traditionally have been hard to provide due to distance from the courthouse, the magnitude of social service needs in this rural area were examined in terms of the feasibility of utilizing a "circuit riding" social worker, mobile unit, or a branch office in the area to better meet social service needs. A third purpose of the study was to assess the acceptability of increased services in the area by local residents.

A questionnaire was personally administered to 112 residents of the area selected for their knowledge of local human service needs. Seventeen known clients were among these respondents. An additional 45 survey instruments were mailed to clients in the target area of which 13 responded. Thus, social service needs were assessed from a sample of 125 family units, including 30 client

families. The six most cited social problems by respondents (50 percent or more) were: alcoholism, special needs of the elderly, marital discord, delinquency, drug abuse and mental illness.

The respondents indicated support for additional service provision in the area. While 66 percent responded that local people had reasonable access to services, 83 percent favored a branch office in the local area. Sixty-four percent favored the assignment of a full-time social worker to the area. A high 73 percent said they would refer people if a branch office was located in the area. A very strong 83 percent favored the "circuit rider" concept, where a social worker would be in each of the communities for some time each week. There was a strong indication that a natural helper system could be easily organized in this area. Seventy-eight percent of the respondents said that there were already people in their community who helped out people in need.

Change to Result From the Needs Assessment

The Iowa Code requires the County Social Service agencies to have a Board of Social Welfare. This cannot be changed at this time, however, services can be organized across county lines. Because the concept is new and experimental, a Citizens' Task Force will be organized. The membership of this Task Force will consist of community leaders, service consumers and client advocates. The Council will consist of approximately 20 persons and will have among its membership, one representative from the Board of Social Welfare in each of the two counties served. It will be the function of this Council to assist in the design of service needs for the geographic area as well as assist in areas of augmentation of professional and para-professional personnel through a comprehensive use of volunteers. It would be unrealistic to assume that a rural agency would ever have enough personnel to meet the total need of the geographic and population area the agency would be serving. Thus, augmenting systems need to be developed, such as the "Natural Helper Program." Resources in the area of services to families with protective services to children and adults need to be creatively mobilized. Two townships in Cedar County and six rural townships in Clinton County are the targeted areas of this new Rural Delivery Program. A site location or a central location will be established in the community of Wheatland. In this community, a clerk-typist/receptionist would be employed to take all telephone calls. Also, integral in this type of

structure might be the use of Citizen Band radio communication between the central site location and the community where the social worker and/or income maintenance worker may be working. Within these eight rural townships there are seven villages. As per the needs survey it was shown that the communities desired to have a circuit type service delivery system since one of the major problems is the lack of transportation. When service delivery is begun, integration of this circuit rider concept will be important. Also planned is a high degree of cooperation with the local Community Action Agency to coordinate services of both agencies. A research component is being built into the project in order to validate the needs survey as well as the continuance of service provision and future staff needs.

FOOTNOTE

[1]For a more complete report of the needs survey, see: "A Social Service Needs Assessment of Designated Rural Communities in Cedar and Clinton Counties," by James R. Cline, Craig R. Mosher, and Joanne Soper, October 1976, available from Craig Mosher, School of Social Work, University of Iowa, Iowa City, Iowa.

APPENDIX A

TABLE 1

PERCEPTIONS OF SOCIAL PROBLEMS

Figures are percentage for each item; items are arranged in order of agreement

CONCERNS (PROBLEM) IN COMMUNITY	STRONGLY AGREE	AGREE SOMEWHAT	DISAGREE SOMEWHAT	STRONGLY DISAGREE	NO ANSWER OR DON'T KNOW
Alcoholism	29.6	37.6	16.0	7.2	9.6
Elderly Persons with Special Needs	29.6	33.6	17.6	9.6	9.6
Marital Discord	20.2	42.7	14.5	6.5	16.1
Delinquency	17.6	40.8	14.5	14.4	8.0
Drug Abuse	22.4	32.8	14.4	12.0	18.4
Mental Illness (emotional problems)	12.8	37.6	19.2	12.8	17.6
Poverty	15.2	31.2	23.2	21.6	8.8
Child Abuse and Neglect	10.5	31.5	18.5	18.5	21.0
Lack of Child Care Facilities	15.2	25.6	23.2	24.0	12.0
Inadequate Housing	14.6	26.0	24.4	22.8	12.2
Inadequate Transportation	19.2	20.0	20.0	26.4	14.4
Physical Handicaps (including blind, deaf, dumb)	8.8	29.6	20.8	27.2	13.6
School Related Problems	12.9	25.0	20.2	18.5	23.4
Mental Retardation	11.2	25.6	25.6	20.0	17.6
Unemployment	13.6	14.4	29.6	16.4	16.0

APPENDIX A

TABLE 2

ACCESS TO SERVICES

Percentage agreement or disagreement with each statement

STATEMENT	STRONGLY AGREE	AGREE SOMEWHAT	DISAGREE SOMEWHAT	STRONGLY DISAGREE	NO ANSWER OR DOESN'T APPLY
1. People in this community are informed of Dept. of Social Services goals & policies.	16.8	24.0	27.2	22.4	9.6
2. The quality of services that are provided by Dept. of Social Services (Tipton or Clinton) is adequate.	26.4	24.0	16.8	5.6	27.2
3. Dept. of Social Service personnel in Tipton/Clinton have been uncooperative with me.	4.0	5.6	12.8	43.2	34.4
4. Community residents have reasonable access to services provided by Dept. of Social Services in Tipton/Clinton.	36.0	29.6	18.4	5.6	10.4
5. There are inadequate resources (day care, counseling, social center, etc.) available to meet the social needs in this community.	21.0	28.2	19.4	19.4	12.0
6. There are people in this community who help out those in need.	44.0	33.6	12.0	4.0	6.4
7. There are people in this community who need social services who are not getting them.	16.8	28.8	17.6	16.0	20.8
8. The Dept. of Social Services should assign a full time social worker to serve small communities in this area.	44.0	20.2	5.5	16.5	13.8
9. I would refer more people to Dept. of Social Services if there were an office closer by.	22.6	32.3	15.3	15.3	14.5

APPENDIX A

TABLE 2

ACCESS TO SERVICES

(continued)

STATEMENT	STRONGLY AGREE	AGREE SOMEWHAT	DISAGREE SOMEWHAT	STRONGLY DISAGREE	NO ANSWER OR DOESN'T APPLY
10. A social service branch office in a small town near by would provide easier access to services for clients.	50.8	32.3	4.8	9.7	2.4
11. Local needs for social services could be met by a social worker who would be in a different community in this area each day of the week.	44.7	38.2	5.7	4.9	6.5

TABLE 3

RESPONDENTS HAD CONTACT WITH TIPTON/CLINTON D.S.S. IN PAST SIX MONTHS	PERCENT
YES	35.5
NO	62.1
NO RESPONSE	2.4

APPENDIX A

TABLE 4

PREFERENCE FOR LOCATION OF D.S.S.BRANCH OFFICE	PERCENT
WHEATLAND	56.2
LOWDEN	14.3
LOST NATION	13.4
CALAMUS	10.7
TORONTO	4.5
MASSILLON	0.9
ELWOOD	0.0

TABLE 5

WOULD REFER CASES TO A NEW D.S.S. BRANCH OFFICE	PERCENT
YES	72.8
NO	26.3
NO RESPONSE	0.9

TABLE 6

CLIENT'S PROBLEMS GAINING ACCESS TO TIPTON/CLINTON D.S.S	PERCENT
TRANSPORTATION	64.0
MONEY	4.0
INFORMATION	4.0
NONE	28.0

APPENDIX A

TABLE 7

WILLINGNESS TO SERVE ON CEDAR/ CLINTON SOCIAL SERVICES ADVISORY COUNCIL	PERCENT
YES	49.2
NO	50.8

1970 CENSUS DATA ON EIGHT SELECTED TOWNSHIPS

TABLE 8

RESIDENCE	POPULATION
URBAN	0000
RURAL NON-FARM	3863
RURAL FARM	2814
* TOTAL *	* 6677 *

TABLE 9

AGE	PERCENT
0 - 9	17.8
10 - 20	18.9
21 - 34	14.8
35 - 54	22.0
55 - 61	8.8
over 61	17.7

APPENDIX A CENSUS DATA (cont.)

TABLE 10

OCCUPATION	PERCENT
PROFESSIONAL & TECHNICAL	5.8
FARMERS & FARM MANAGERS	24.7
MANAGERS & OFFICIALS	8.0
CLERICAL & KINDRED WORKERS	7.9
SALES WORKERS	2.5
CRAFTSMEN & FOREMEN	9.4
OPERATIVES	24.0
SERVICE WORKERS	11.5
FARM LABORERS & FARM FOREMEN	3.3
LABORERS EXCEPT FARM & MINERS	2.9

TABLE 11

TOWNSHIP	PERCENT BELOW POVERTY LEVEL
MASSILLON	19.1
SPRINGFIELD	11.1
BROOKFIELD	3.9
SHARON	11.7
LIBERTY	15.5
ORANGE	20.1
OLIVE	2.6
SPRING	7.5

APPENDIX A CENSUS DATA (cont.)

TABLE 12

DISTANCE FROM CLINTON

COMMUNITY	MILES FROM CLINTON
ELWOOD	37
GRAND MOUND	23
LOST NATION	43
CALAMUS	28
TORONTO	37
WHEATLAND	22
* AVERAGE *	* 33 *

TABLE 13

DISTANCE FROM TIPTON

COMMUNITY	MILES FROM TIPTON
MASSILLON	17
LOWDEN	16
* AVERAGE *	* 16.5 *

TABLE 14

POPULATION DISTRIBUTION AROUND WHEATLAND

COMMUNITY	MILES FROM WHEATLAND	TOWNSHIP POPULATION
ELWOOD	17	514
GRAND MOUND	13	1060
LOST NATION	11	932
CALAMUS	8	798
TORONTO	6	535
MASSILLON	11	440
LOWDEN	7	1070
* AVERAGE *	* 10.4 *	

APPENDIX B

QUESTIONNAIRE

SOCIAL SERVICE NEEDS SURVEY

This survey is designed to provide the District Eight Department of Social Services with information regarding the present social service delivery system, and the social needs of small communities in Cedar and Clinton counties.

Your answers will remain anonymous. Answers will be aggregated so no individual responses can be identified. Your name will never be attached to your answers in any way.

Your full cooperation is appreciated and will greatly assist the Department of Social Services in meeting social needs in this area. You were selected as someone who might know about social needs in this community.

APPENDIX B

SOCIAL SERVICE NEEDS SURVEY

PART ONE

Respondent Sociodemographic Data

1. Do you live in Cedar/Clinton counties?
   - 1a. Yes
   - 1b. No

2. Place of Residence
   - 2a. in town
   - 2b. rural farm
   - 2c. rural non-farm
   - 2d. no response

3. How many years have you lived or worked (whichever is greater) in this county?
   - 3a. 0-3 years
   - 3b. 4-6 years
   - 3c. 7-9 "
   - 3d. 10-20 "
   - 3e. over 20

4. Age of Respondent
   - 4a. 20-30 years
   - 4b. 31-40 "
   - 4c. 41-50 "
   - 4d. 51-60 "
   - 4e. over 60

5. Sex of Respondent
   - 5a. Male
   - 5b. Female

6. Is your job primarily concerned with providing human services to people in this area?
   - 6a. Yes
   - 6b. No

7. Are you engaged in other activities (organizations) which provide community services outside your normal working hours? (If yes, please specify.)
   - 7a. Yes
   - 7b. No
   - 7c. No response

8. Approximate number of hours engaged in outside social services activities per week.
   - 8a. 1-3
   - 8b. 4-6
   - 8c. 7-9
   - 8d. 10 and greater

APPENDIX B

PART TWO

These are areas of concern of the Department of Social Services. To what extent do you agree of disagree that they constitute a problem in this community?

	STRONGLY AGREE	AGREE SOMEWHAT	DISAGREE SOMEWHAT	STRONGLY DISAGREE	NO ANSWER OR DOESN'T APPLY
Child Abuse and Neglect					
Alcoholism					
Drug Abuse					
Delinquency					
School Related Problems					
Mental Retardation					
Physical Handicaps (including blind, deaf, dumb)					
Marital Discord					
Mental Illness (emotional problems)					
Poverty					
Inadequate Housing					
Unemployment					
Inadequate Transportation					
Lack of Child Care Facilities					
Elderly Persons with Special Needs					

Other (specify_____)

APPENDIX B

PART THREE

Please tell me to what extent you agree or disagree with these statements.

	STRONGLY AGREE	AGREE SOMEWHAT	DISAGREE SOMEWHAT	STRONGLY DISAGREE	NO ANSWER OR DOESN'T APPLY
1. People in this community are informed of Dept. of Social Services goals & policies.					
2. The quality of services that are provided by Dept. of Social Services (Tipton or Clinton) is adequate.					
3. Dept. of Social Service personnel in Tipton/Clinton have been uncooperative with me.					
4. Community residents have reasonable access to services provided by Dept. of Social Services in Tipton/Clinton.					
5. There are inadequate resources (day care, counseling, social center, etc.) available to meet the social needs in this community.					
6. There are people in this community who help out those in need.					
7. There are people in this community who need social services who are not getting them.					
8. The Dept. of Social Services should assign a full time social worker to serve small communities in this area.					
9. I would refer more people to Dept. of Social Services if there were an office closer by.					
10. A social service branch office in a small town nearby would provide easier access to services for clients.					

APPENDIX B

PART THREE CONT.

	STRONGLY AGREE	AGREE SOMEWHAT	DISAGREE SOMEWHAT	STRONGLY DISAGREE	NO ANSWER OR DOESN'T APPLY
11. Local needs for social services could be met by a social worker who would be in a different community in this area each day of the week.					

12. I have had contact with or have referred people to the Department of Social Service staff in Tipton/Clinton within the past 6 months. Describe.

    a. Yes
    b. No
    c. No response

13. Where would you suggest a social service branch office be located for the seven communities (Wheatland, Lowden, Lost Nation, Calamus, Toronto, Elwood, Massillon)?

14. Would you have referred cases to a social service branch office if it existed? If so, what kind?

    a. Yes
    b. No
    c. No response

15. What problems do clients have in gaining access to the Department of Social Service office in Tipton and Clinton?

    a. None
    b. Transportation
    c. Distance
    d. Money
    e. Information/referral
    f. Attitude

16. Would you be willing to serve on a Social Services Advisory Council to further cooperation between Cedar and Clinton counties?

    a. Yes
    b. No

RURAL DEVELOPMENT AT THE SCHOOL OF SOCIAL DEVELOPMENT, UNIVERSITY OF MINNESOTA - DULUTH

John Musick

A New Concept of Development for Northern Minnesota

Northern Minnesota is a largely rural area which has many examples of the results of defining "rural development" to be synonymous with "economic development." Its natural resources have been a much sought-after prize for large absentee-owned mining and logging companies for many years. With very few exceptions, the people of the area have welcomed these developments and have been very willing to exchange the resources of their land for economic returns. While this exchange has benefited many people, there have been serious dislocations caused by the lack of attention to other aspects of development.

The School of Social Development is committed in its charter to serving Northern Minnesota. One of our first steps in fulfilling this commitment has been to seriously question the development model adhered to (at least implicitly) in many Northern Minnesota communities.

Of course we can understand that economic development is fundamental in the minds of many people, especially since Northern Minnesota has had a depressed economy for many years. We are not trying to say that economic development is not vital. And we certainly are not criticizing people who have pursued economic development for Northern Minnesota. But we feel that it is important from our position as academics to question present practices and suggest ways in which they can more effectively serve the needs of people.

The basic philosophy of the School of Social Development is that the social institutions existing in any community must be engaged in a constant process of change which keeps them in touch with the needs of people they serve. Further, this process of change must be actively initiated and encouraged by action both from inside and outside the institution. The art of bringing about such change is what we call "social development."

The model of development we are proposing follows from our perception of the ill effects of exclusive emphasis on economic development and our commitment to promoting constructive change in societal institutions. For us, development

means the process of bringing about a better fit between the needs of people and the functioning of *all* the institutions in a community.

The economic institutions must be capable of providing both a sufficient level of material resources to meet the needs of the people and stability within the system. Silver Bay, Minnesota is a good example of a community where the economy met the short-term needs of the people very well, but has not provided any stability. Without going into the arguments about where Reserve Mining Company should dump its wastes, it is clear that the city is overly dependent on one employer, to the point where it will cease to exist if that employer ceases operation. Regardless of the outcome of the Reserve issue, it is clear that social development in Silver Bay will require changes in the economic institutions that will provide stability as well as prosperity.

Our model of development also requires serious attention to the "political institutions" of a community. It is necessary to include all decision-making institutions that affect the public good in our definition of "political." Thus, we include not only elected officials, but every appointed official who is making decisions that affect the public good, from welfare department directors to dog catchers. We also include private decisions which affect the public good, such as the decision of a public utility to raise its rates.

It often happens in both rural and urban settings that a significant portion (even a majority) of people are effectively eliminated from any effective influence over these decisions. The more they feel powerless the less they try to act within the political system and a vicious circle ensues. Given our commitment to having institutions act for the interests of their constituents, it is incumbent on us as social developers to reverse this situation.

Finally, we must look at the formal and informal social institutions which exist in every community. There is a wide variety of such institutions. In larger communities, formal social institutions, such as churches, social clubs, unions, and farmer organizations will predominate. In very small communities, informal social institutions will be more prominent. For instance, in Floodwood Minnesota, the only *formal* institution to deal with medical needs is an ambulance service. However, there is a very elaborate network of people who work to meet peoples' medical needs, ranging from a retired pharmacist who gives advice on medicines and treatments to an elderly man who is said to have "healing power"

in his hands.

Regardless of the size of the community, but especially in rural areas, these informal institutions are extremely important in that they are the most frequent and important way in which the needs of individuals are identified and acted upon in the public sector. It is at this level that the ordinary person develops his/her experience of either power or frustration. If most people regularly experience frustration at this level, a passive, non-active community will develop. On the other hand, if people find they can get things done through their small social institutions, many will move to larger issues that serve the needs of a broader constituency. So it is an important part of social development to see to it that a community has strong small-scale social institutions that will be able to act with effectiveness on the needs of people.

Implementing the Model

So our objective in social development must be to increase the ability of people to effectively demand that all institutions at all levels meet their needs. To achieve this, individual people and small-scale and informal social institutions must have power at least commensurate with the power of large-scale institutions which make decisions affecting them. But this power must be wielded in a truly democratic fashion to meet the needs of all rather than a few. The only way to achieve this is to build citizen-controlled organizations. These must be multi-issue organizations so that they can respond to peoples' needs in many areas. In a pluralistic society, they must also be relatively small and numerous so that they can really represent a variety of needs and interests.

Such organizations are not natural occurences, just as welfare departments and county governments are not "natural" but the product of very conscious, deliberate organization-building efforts. Citizen groups designed to engage in the decision-making process of these major institutions must be developed by a similar deliberate process.

Our program in rural development at the School of Social Development is designed to give students at least beginning skills and some practice experience in developing such organizations in rural areas. One of the most fundamental skills we aim to develop is a way to elicit and understand the needs of people. Although this may seem obvious and simple, it becomes very difficult the more

a person is schooled in traditional research techniques and the more his perspective is affected by the perspective of social service agencies. Traditional research techniques and social service agencies train people to elicit standardized needs that fit into the service purview of a given agency. To counteract this we train our students in unstructured, ethnographic interviewing which requires them to talk to people about whatever their needs might be, without any beginning assumptions and with no attempt to fit what they are saying into a "need" for one of the services his or her agency has to offer.

Another important set of skills for the rural developer is providing people with the technical expertise to get things done in our increasingly sophisticated and technological society. One of the most basic skills is helping people move from a generalized problem (an awareness that something is wrong) to a specific issue (something that can be changed about the problem). Once an *issue* has been chosen for action, the developer must help the organization decide which action it will push for. Often there are many ways of promoting change and it may not be a *simple* matter to choose the most beneficial. The developer must then advise his people on how to bet the action they want. This will always mean developing arguments for their position and being able to answer counter-arguments. It may mean finding ways of building power to push their alternative to counteract the power of an opposing institution. This may mean developing the political power of numbers of people, or the power of the opposing institution's own rules or the laws which govern it.

One of the most important functions of the developer in this process is helping people build an on-going organization that will enable them to exercize power on a continuing basis in many areas, rather than simply "winning" a particular issue. In other words, it is not sufficient to get a problem taken care of through the political influence of an indivudal, because this does nothing to build the power of the group or the sense in the rank-and-file that *they* can get things done through cooperative effort. And when the influential individual is no longer around, the organization will be ineffective. This is often a difficult matter for people to understand in specific situations and it takes a great deal of skill on the part of the developer to get them to adopt this perspective.

Preparing Our Practitioners to Implement this Model

We have included many of the skills of practice and analysis needed for practitioners of this model in our classroom-based curriculum. Our research classes, particularly through our course in qualitative research methodology, prepares students for unstructured ethnographic interviewing. We also give them basic skills in gathering strategic information that will be useful for a citizen's organization. Theories on how to build such an organization are taught in our community organization class, along with tools for analyzing the basic social structure of a community. For students electing the course in rural development we provide some experience in using these skills in a specific rural community. In the two years this course has been taught we have looked at two rural communities in Duluth. In our first year, we focused on Floodwood, Minnesota. This is a declining rural town that was once a large agricultural center. It is now mainly a bedroom community that is in danger of totally losing its economic base. In our second year, we looked at Silver Bay, Minnesota. As mentioned earlier, this is a one-industry rural community that is in danger of losing its entire economic base. As part of the course requirements, students did the analysis of the community which could be needed to begin the type of development I have described. Although we were not able to carry out the development project, we turned our information and recommendations over to agencies working in the communities.

The opportunity for actual practice in implementing a development project in a rural community exists within our five-month block field program. Unfortunately, we have had very few students choosing this option. One of the chief reasons for this is that so few agencies are set up to do this type of development, since most simply provide a specific "social service." We are attempting to provide more opportunities for such experience to our students in several ways. We are working with the Center for Urban Encounter (Minneapolis) and the Catholic Archdiocese of Minnesota to develop a rural-based training center that will set up precisely to provide the type of development service to rural communities which I have described. We are also attempting to secure funding for a rural development program based in our School. This program would combine the efforts of a small professional staff, faculty members at the School, and students in providing professional assistance for development projects in rural areas of our region. It is our very strong belief that a rural development center of this kind would serve the interests of our students, our faculty, and the people or rural Minnesota and Wisconsin.

7 A BIBLIOGRAPHY OF SOCIAL WORK IN RURAL AREAS

The various disciplines preparing human service professionals for practice have traditionally been urban based and urban problem oriented. As a result, there has not been an abundance of teaching materials and resources developed to prepare individuals for the rural practice setting. In fact, in the field of social work, only two small texts have been able to receive national distribution and attention: *The Rural Community and Social Casework*, by Josephine C. Brown, Family Welfare Association of America, 1933; and *Social Work in Rural Communities: A Book of Readings*, by Leon H. Ginsberg, Council on Social Work Education, 1976.

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Special thanks are due to the following individuals and publications from whom we borrowed citations for this bibliography:

Paul Sundet
Joanne Mermelstein
Carol M. Schultz

of

The University of Missouri - Columbia School of Social Work

UNPUBLISHED SOURCES

Many of the resources for studying rural social work are in unpublished form. A partial listing from the 1975 ASPA annual meeting and the first National Institute on Social Work in Rural Areas follows. Copies of these papers may be obtained from the authors.

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